Cooperation for RURAL HEALTH

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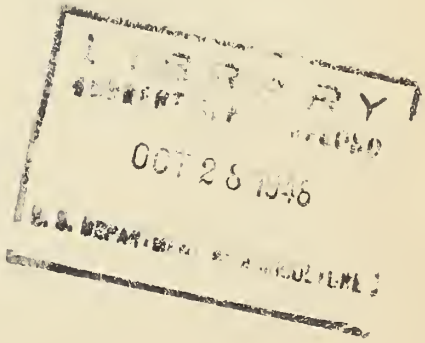
FARM CREDIT ADMINISTRATION
U. S. DEPARTMENT OF AGRICULTURE, WASHINGTON, D. C.

MISCELLANEOUS REPORT 123 SEPTEMBER 1948



UNITED STATES DEPARTMENT OF AGRICULTURE
FARM CREDIT ADMINISTRATION
WASHINGTON 25, D. C.
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The Cooperative Research and Service Division conducts research studies and service activities relating to problems of management, organization, policies, merchandising, sales, costs, competition, and membership arising in connection with the cooperative marketing of agricultural products and the cooperative purchase of farm supplies and services; publishes the results of such studies; confers and advises with officials of farmers' cooperative associations; and cooperates with educational agencies, cooperative associations, and others in the dissemination of information relating to cooperative principles and practices.

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FARM CREDIT ADMINISTRATION
U. S. DEPARTMENT OF AGRICULTURE
WASHINGTON 25, D. C.

SUMMARY

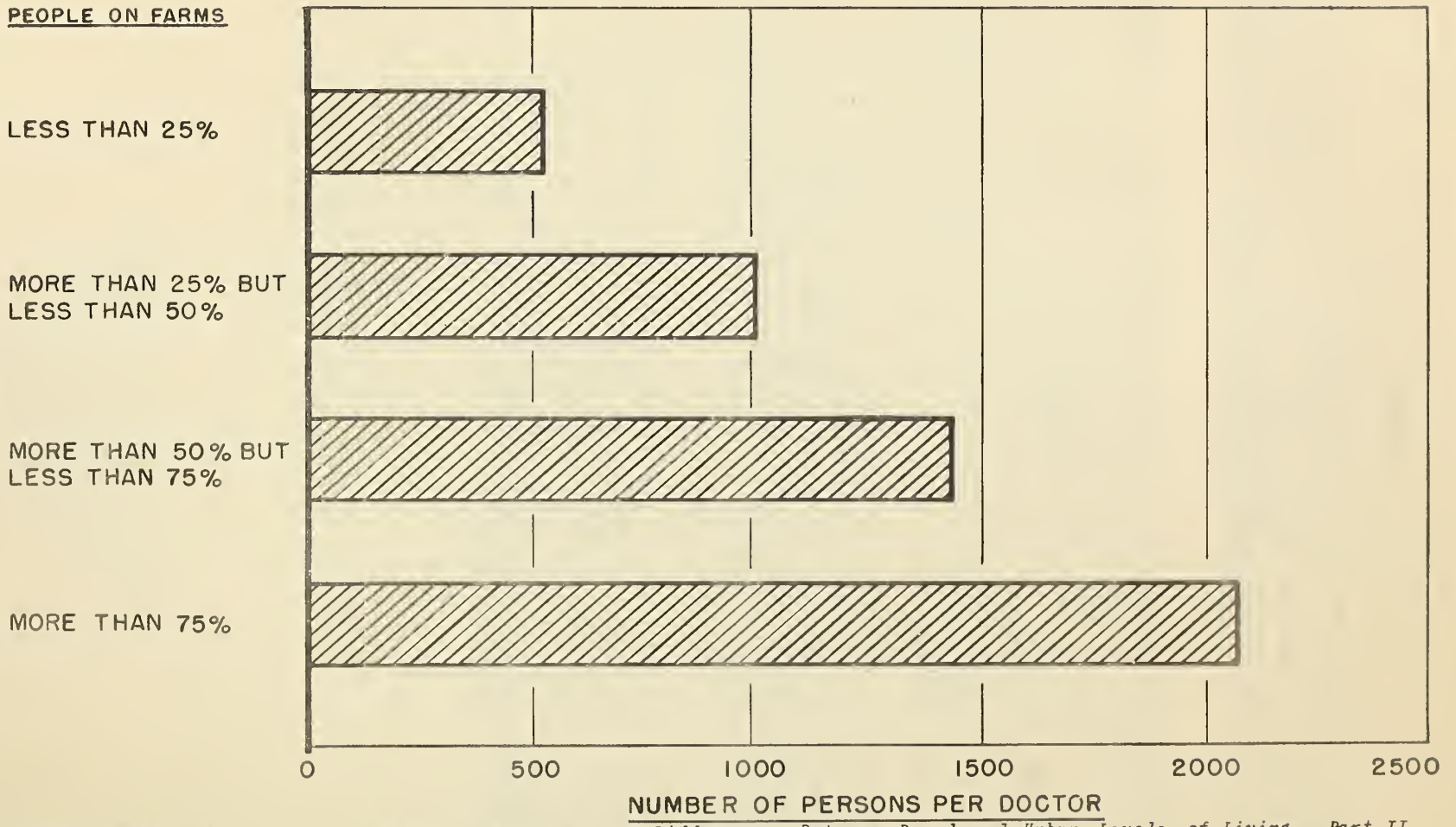
Farmers' cooperatives have joined in health discussion and planning councils, contributed to funds for building local hospitals and clinics, helped finance medical students, and taken other general measures to improve rural health facilities and services. The problem of payment for service, however, takes top rank in much of their thinking, planning, and action.

As individuals, the members of farm co-ops often find it difficult, if not impossible, to fit the costs of health services into their family budgets. They are applying to the problem of budgeting for the costs of health services the same principle they have long applied to other problems - teamwork. In some cases the teamwork that originally led to a co-op for performing an essential business service has simply been extended to include one more service. Thus, through their farm business co-ops many farm families have been able to enroll in plans for group budgeting of hospital costs or other sickness and accident expenses.

In other cases, the teamwork principle has been carried beyond a single farmers' co-op. Local cooperative groups, working with other local organizations, have formed a new cooperative association. The new association has had the special purpose of developing and operating a local group budgeting plan suited to local conditions and needs. Usually it has had the added purpose of making health facilities and services needed in the area available.

This report reviews some of the activities in the field of rural health carried on by farmers' cooperatives during the period 1945-47. First, it summarizes briefly certain broad general measures co-ops have taken to improve health services for farm people. Next, it outlines in detail selected examples of three systems of prepayment. Finally, it makes some suggestions for interested groups in rural areas where little, if anything, has yet been done.

NUMBER OF PERSONS PER DOCTOR, 1942, IN COUNTIES GROUPED ACCORDING TO PERCENTAGE OF PEOPLE LIVING ON FARMS



SOURCE: McKain, Walter C., Jr. and Flagg Grace L. Differences Between Rural and Urban Levels of Living. Part II. U. S. Bureau of Agricultural Economics. Washington, D. C., 12 pp. 1948. (Processed.) Adapted from Table 5, page 6.

Figure 1. - The number of persons per doctor is only one indication of the shortage of health services typical of predominantly rural areas.

COOPERATION FOR RURAL HEALTH

By

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A farm family has no asset of greater value than good health. Moreover, good health for the individual family helps build good health and prosperity for the whole community. Yet rural families often find their areas deficient in facilities and services to maintain health. (See figure 1.) And they often find no way to fit the costs of needed health services into their budgets without giving up other family necessities. As a result rural people have been asking some specific questions: How to get and keep doctors in our communities? How to get adequate hospitals, clinics, and public health units? How to help individual families afford and the community as a whole support the health services required to maintain individual and community health and prosperity?

Farmers' cooperative associations are among the rural organizations trying to answer these questions. This report for the years 1945-47 presents a general picture of what farm co-ops have been doing to bring "better health for more people" to rural America.

Information was obtained by correspondence and by personal visits to some of the organizations studied. No attempt was made to canvass the entire field. Nor does the report include statistical summaries showing the extent to which co-ops and their members have taken part in different types of programs.

BROAD GENERAL MEASURES

Widespread understanding of rural health needs is essential before sound programs for improvement can be developed. Rural needs are gradually becoming more widely understood as rural people secure better representation on local, State, and national health councils.

Farmers' cooperatives are among the organized groups through which rural people are making themselves heard. The National Council of Farmer Cooperatives, for example, is represented on the Rural Health Subcommittee of the National Advisory Council set up under the hospital

NOTE: The generous assistance of many individuals and organizations is gratefully acknowledged. Among the organizations to which special thanks are due are Group Health Mutual, St. Paul, Minn.; the four cooperative hospitals reported upon; the Cooperative Health Federation; and the Blue Cross Plan Commission. Thanks are also due those persons in the U. S. Department of Agriculture and the Federal Security Agency who reviewed the report and made helpful suggestions.

law passed by Congress in 1946.[1] Southern States Cooperative, Inc., of Richmond, Va., has a place on the Virginia's Rural Health Council. Cooperative associations have also taken part in the annual rural health conferences called by the American Medical Association.

Rural people, themselves, need better understanding of their health situation before sound rural health programs can be worked out. "Why don't more farm people get adequate medical service?" was a question asked members of Ohio discussion groups several years ago. "Lack of understanding of health needs" was the answer given by 1,400 persons - more than half of those answering the question. Discussion groups sponsored by cooperatives and other farm organizations have promoted better understanding by investigating the rural health situation. Discussions at regular co-op meetings and articles in co-op papers and magazines have served a like purpose.

But the habit of co-op members is to do something about problems - not just talk about them. So a growing number of cooperatives are taking part in community efforts to get more doctors, more hospital beds, more public health units - in short, more of all that modern medicine has to offer. They are also helping establish systems of prepayment in rural areas.

Local discussion of rural health problems in which co-op members took part in one State led to such projects as setting up maternal and child health clinics, getting the hot lunch program started in rural schools, and introducing procedures for rabies control. The members of a Nebraska farmers' co-op recently voted to donate their net returns for a year's operations to a local hospital. Their vote was based on the belief that "a modern hospital would be of more benefit to them than cash...." A Florida citrus co-op appropriated funds to build a public health center in its headquarters community. Cooperatives in other areas have also contributed to funds for hospitals and other health facilities.

At its annual meeting in 1947, the Illinois Agricultural Association voted to advance $1,000 annually over a 5-year period to selected medical students. These students must agree to practice general medicine in a town of less than 5,000 until their loan has been repaid. Two will be financed by the association during the school term beginning in the fall of 1948. Two more will be financed each year through the school term ending in 1953.

The medical scholarship loan plan was developed by the State Medical Society in answer to the IAA's repeated statement of the need for more doctors in the communities where its members live. The Medical Society

[1]Pub. Law 725. 79th Cong., 2d sess. [S. 191] AN ACT To amend the Public Health Service Act to authorize grants to the States for surveying their hospitals and public health centers and for planning construction of additional facilities, and to authorize grants to assist in such construction. Approved August 13, 1946.

will match the association's contribution. A total of $100,000 will be made available in the loan fund, enough to finance a 4-year medical course and year's internship for 20 students. Each student applying for a loan must have completed 3 years of pre-med training. He must also have the written recommendation of a joint county committee made up of representatives of the local medical society and the IAA. The program will be on trial for a 5-year period. Thereafter it may be continued if the results are encouraging.

During 1945, the Texas Federation of Cooperatives along with other rural organizations of the State helped secure a law providing for cooperative hospitals in rural communities. In 1947 the Wisconsin Association of Cooperatives worked with the State Medical Society and other groups for a new State law permitting lay groups to set up systems of prepayment for health services and to build health facilities on a cooperative basis. In about a dozen States at the present time local and regional farmers' cooperatives are helping develop rural health cooperatives.

MEASURES FOR GROUP BUDGETING

How to make farm dollars cover the cost of health services farm families need? That has been one of the hardest problems faced by members of farm co-ops as they looked for ways to improve their health situation.

A farm family, like other families, knows just about how much it will have to pay for food, clothing, household repairs, and other family needs during any one year. It can plan for those needs accordingly. But the average family doesn't know ahead of time whether its doctor and hospital bills will amount to exactly zero - as they sometimes do in a year when a family is lucky - or whether they will be $10, $100, or even $1,000. A family may set aside $50 or $100 to meet possible sickness and accident expenses. It may find that amount either far too large or far too small.

Problems that can't be solved by one family alone, however, often become much easier when a group of families tackle them together. Co-op members have long applied this basic cooperative principle to problems of marketing their produce and purchasing supplies. Now they find the same principle can be applied to the problem of budgeting for hospital costs or other sickness and accident expenses.

They have learned, however, that a variety of group budgeting plans are available. All the plans make it possible for families, working together, to ease the burden of expense for any one family at any one time. All are based on the fact that the need for hospital care and related services can be predicted with considerable accuracy for a large group of families even though it usually can't be predicted for a single family. As a result, the cost of needed services can be estimated in advance for a large group. Then this estimated cost can be divided among all families in the group.

Each of the budget plans requires the families taking part to make a regular, periodic payment into a common fund. The amount of each family's payment is based on its share of the estimated total cost for all families in the group. The bills incurred by any family in the group for services covered by the plan are met from the common fund.

Of course, under such group systems of advance payment or prepayment an individual family probably will make an overpayment in some years and an underpayment in other years for the benefits the family actually receives. Over a period of years, however, the over- and underpayments are likely to be evened out.

Although prepayment plans are alike in basic principle, they vary in annual cost per family, type and quantity of benefits, and other ways. Co-op members now use three general types of plans. One, prepaid hospital service, usually provides benefits in service. There is a growing tendency among organizations of this type, however, to provide benefits partly in cash and partly in service. A second type, handled according to established insurance methods through insurance companies, provides benefits in cash. The third type, carried out through local cooperative associations formed for the special purpose of making health services available under a local budget plan, provides benefits in service.

The prepaid hospital service and insurance plans have been extensively used in urban areas for some time. They are now slowly gaining some importance in rural areas. These two types of plans usually extend their operations over at least a large part of a State. Sometimes they extend beyond the borders of a single State. Members of cooperative associations customarily must enroll in these plans on a group basis just as employees of a business office or industry are required to enroll. Except when insurance is secured through mutual or similar types of insurance companies, families enrolled in prepaid hospital service or insurance plans usually have no voice in determining policies or in business management.

The cooperative plan developed first in rural areas. Usually an organizing group has two objectives: (1) To improve local health facilities and services or to make them available when necessary; and (2) to help members of the cooperative budget their health costs through a prepayment plan developed locally and adapted to local conditions.

A rural cooperative health association typically draws its membership from a small area, including not more than one or two counties and parts of adjoining counties. Families can join the health association on an individual family basis just as they join other cooperatives. Member families have a direct voice in determining general policies of a non-professional nature. They also have a direct voice in business management.

The way the three types of plans are set up and their operating methods are described in the following pages. Special examples of each type of plan have been selected for rather detailed discussion.

HOSPITAL SERVICE PLANS

Hospital bills are often large; they strike suddenly; and they must be paid without delay. For these reasons, hospital bills seem to many people the most alarming single item of the costs of sickness.

About one out of 10 persons - taking the country as a whole - will go to the hospital during any one year. The unlucky ones will seldom know in advance how much they will have to pay. Usually an individual or family won't be prepared to meet the cost out of their regular living budget.

Stated briefly, those are the facts behind group plans for prepaid hospital service. To individual members of a group, the plans are a means of paying hospital bills in advance. Each member of a group pays a small amount periodically. In return any member of the group can use to the full extent necessary the prepaid hospital services arranged for by the hospital service organization with a particular hospital or group of hospitals.

Group prepayment for hospital service is not a new idea. Groups of persons working in a single factory, office, or industry have long used various systems of paying hospital bills in advance on a group basis. Sometimes arrangements for service were made with one hospital; sometimes with more than one hospital. Not until the 1930's, however, did the idea of group prepayment for hospital service really get well started.

Blue Cross Plan

At the present time the Blue Cross plan is the most widely used type of prepaid hospital service organization. At least one Blue Cross organization operates in nearly every State. The organizations in different parts of the country vary in details of set-up and operation. They are alike in basic structure and methods.

The members of farmers' co-ops scattered from California to New York and from North Dakota to Kentucky are now enrolled in Blue Cross organizations. Because the Blue Cross plan is so widely available and its use by co-op groups has been rather extensive, this type of prepaid hospital service organization is discussed here in detail.

The American Hospital Association adopted the term "Blue Cross" in 1938 to designate any prepaid hospital service plan which met the standards established by the Association. These standards were slightly modified in 1946. At present they are as follows:

1. Representation of hospitals, the medical profession, and the general public on the governing boards.

2. Nonprofit sponsorship and control.

3. Free choice of hospital and physician with opportunity for all hospitals of standing in the area to become member-hospitals.

4. Benefits guaranteed by member-hospitals.

5. Sound accounting practices and adequate statistical records.

6. No interference with professional relationships.

7. Compliance with principles governing the organization and operation of Blue Cross plans, as established by the American Hospital Association.

Other principles established by the American Hospital Association include adequate general or contingency reserves, equitable payments to hospitals, dignified promotion and administration, sound enrollment practices, and interplan coordination.

By the end of 1947, 85 Blue Cross organizations had been formed in the United States. They covered 27,490,000 persons including 2 million in rural communities and on farms. Every State except Arkansas has at least one Blue Cross plan operating within its borders. Early in 1948 a move was on foot in Arkansas to establish a Blue Cross plan in the State. Thirty-four States and the District of Columbia have a single Blue Cross plan which covers the whole State. Included among these 34 States are New Hampshire and Vermont which are covered by a single plan. Altogether, 3,800 of the public general hospitals in the United States, representing 80 percent of the total bed capacity of all such institutions, are member-hospitals of Blue Cross plans.

Most Blue Cross plans are incorporated and operate under special enabling acts providing for nonprofit hospital service corporations. Most of them are supervised by the department of insurance in the State in which they operate.

Benefits - Blue Cross hospital service plans vary in the amount and types of services they provide. A typical plan offers a subscriber the following service when he goes to the hospital on the advice of his doctor:

1. Bed and board in a semiprivate room, usually defined as a room with 2 to 4 beds. (Almost a third of the plans, however, now make a dollar room allowance while continuing to offer other benefits in service. The change to a dollar room allowance is a recent development.[2]

2. General nursing service.

3. Use of operating room as often as needed during any period of hospitalization.

[2]Reed, Louis S. *Blue Cross and Medical Service Plans.* 323 pp. U. S. Public Health Service, Washington, D. C. 1947. Processed pp. 32-33.

4. Anesthesia as often as needed when administered by a salaried assistant of the hospital.

5. Routine laboratory services.

6. All medicines except oxygen, sera, and intravenous solutions.

7. All surgical dressings and plaster casts.

Prepaid services under a Blue Cross contract usually are limited to a period of 21 to 30 days during any one year for any one person covered. Most plans provide payment of from one-fifth to one-half of the hospital bill for an additional period of 90 to 120 days. Although a few plans limit the benefits for family dependents, most provide the same benefits for all members of the family.

Any subscriber to a Blue Cross plan who needs or wishes a private room, special nursing service, or other special services or accommodations must pay the difference between the cost of the service he uses and that provided under his hospital service contract. The hospital bills the subscriber *only* for hospital service in addition to that which his contract provides. With this exception, the hospital sends its bill to the hospital service organization and is paid direct by the organization.

Blue Cross plans usually provide limited hospital service, if any, for tuberculosis, mental and nervous diseases, quarantinable diseases, rest cures, and diagnostic examinations. Some do not provide service for conditions known to require hospitalization at the time of application. Nor do the plans provide professional services including those of doctors, surgeons, and special duty nurses. As a rule, workmen's compensation and other cases for which service of compensation is available from an agency of the State or Federal Government also are excluded. Usually a prepaid hospital service contract provides maternity care only after a waiting period of from 7 to 12 months following enrollment under a family contract or a contract for husband and wife.

Cost - The cost of enrollment in Blue Cross plans in different parts of the country varies as the result of differences in actual costs of hospital maintenance and consequent differences in hospital rates. Costs also vary because of differences in services provided and other variations among plans. The annual cost in different plans offering semiprivate room accommodations ranges from about $8 to $15 for an individual and from about $15.60 to $39 for a family including parents and dependent children. The annual cost for an individual averages $10.80 for all plans and the cost for a family averages $25.20. Usually subscribers in urban groups pay their *dues* in monthly installments, often by deductions from pay checks. Quarterly, semiannual, or annual payments are also acceptable in most plans and are customary among rural groups. Dues must always be paid in advance.

Most plans originally established three rates: One for a single person, another for a married couple, and a third for parents and children

without regard to number of children. Nearly half of the plans, however, now have only two rates: One for a single person and the other for parents and children. The rate for a family unit includes all dependent children, usually with an age limitation of 19 years. After that age enrollment can be continued by paying the regular rate for a single person. Many of the plans do not cover infants until from 1 to 3 months after birth.

During the last 10 years prepaid hospital service plans have been used increasingly for *family* protection instead of just protection for the employed wage-earner. When the term "Blue Cross" was first adopted, only three out of 10 persons covered by plans approved by the American Hospital Association were family dependents. By 1947, six out of 10 were family dependents.

Enrollment procedure - The membership of most organized groups formed on the basis of a common economic or social interest represents an average cross-section of the public as far as health is concerned. By basing enrollment on such groups, a prepaid hospital service plan can avoid, to a considerable extent, the possibility of becoming overburdened with those who join because they expect to go to the hospital.

Farmers' cooperatives are among the varied types of business and social organizations through which Blue Cross plans enroll farm families. The members of a farm co-op enroll on the same basis as the members of any other rural or urban organization. The officers or designated representatives of the co-op must first negotiate with officials of the hospital plan operating in their area. Usually enrollment is then opened to members of the co-op for a period of several weeks. A certain percentage of the eligible members of the group must enroll during that period or the group will not be accepted.

The percentage of the eligible members of an organization required to enroll varies according to the size of the organization. If the group is small, 100 percent enrollment may be required. Usually from one-half to three-fourths of the members of an organization are required to enroll before a group will be accepted.

About two-thirds of the Blue Cross plans have no age limit for group enrollment. For others, the most common limit is 65. No one is ineligible because of a preexisting ailment, but about half of the Blue Cross plans do not provide hospital service for such ailments, at least during the first year or so of membership.

After accepting a new group, the hospital service plan issues to each person enrolled an individual or family contract and an enrollment card. The latter indicates eligibility for Blue Cross plan benefits in case a subscriber requires hospitalization at any time.

Although up to the present time most Blue Cross plan subscribers have been enrolled through organized business or social groups, many plans follow the practice of opening their enrollment periodically for a

limited time to individuals. Often persons enrolled on an individual basis are required to pay somewhat higher rates, or the benefits they are offered may be somewhat restricted as compared with those offered group subscribers. Customarily a person who, for some reason, leaves the group with which he was originally enrolled, may continue his enrollment on an individual basis.

Enrollment of cooperatives - Reports show that farm co-ops scattered in many parts of the country are now on the enrollment lists of Blue Cross prepaid hospital service plans. Local cooperative creameries and branches of large-scale dairy co-ops are probably the largest single group of cooperatives enrolled. Fruit and vegetable cooperatives, rural electrification associations, mutual irrigation companies, and farmers' mutual fire insurance companies are among other types of farmers' business associations through which farm families have enrolled. Among the States in which Blue Cross plans report enrollment of farm families through their cooperative associations are California, Colorado, Kansas, Kentucky, Michigan, Minnesota, Nebraska, New York, North Dakota, Ohio, and Wisconsin.

Role of a participating group - In a few Blue Cross plans, a rural organization serves only as the basis for enrolling a cross-section of a rural community. Once a group has been accepted, the group organization itself steps out of the picture. Its members pay their dues as individuals direct to the central office of the hospital service plan.

Typically, however, a group is responsible for collecting hospital service dues and keeping certain local membership records. It also helps when enrollment is reopened periodically for a limited time to additional members of the group. Customarily some member of the group is appointed to collect dues and send them to the central office of the hospital plan. Dues usually are collected from the members of rural organizations quarterly, semiannually, or annually.

As a rule, the members of enrolled groups do not take part directly in any way in the policy-making or administration of the nonprofit organization through which they secure prepaid hospital service. A few hospital service organizations, however, have established subscribers' councils made up of representatives of enrolled groups. Periodic meetings of these councils form a more or less effective channel for a two-way flow of information and suggestions.

County-wide associations - In some cases groups of rural families have formed county-wide associations on a cooperative basis with enrollment in a Blue Cross plan as one of their objectives. These associations function as a method of community enrollment. An effort is made to bring into their membership as large a part as possible of a county's rural population, including families living in small towns as well as those on farms.

This type of community enrollment program has been most widely used in Iowa. There 67 county associations, known as county health improvement

associations, had been organized by the end of 1947. Thirty-three thousand families in 69 Iowa counties belonged to the associations. The member-families included about 100,000 rural people, nearly one-fourth of the total Blue Cross enrollment in the State.

Similar county associations are found in a few other localities. The Weld County Agricultural Health Association, with headquarters at Greeley, Colo., probably is the largest. Its membership has nearly doubled since 1945. The association now includes 8,000 persons, all outside of Greeley, the county seat and the only town in the county with a population of more than 10,000. Less than a half-dozen other towns in Weld County have more than 1,000 people.

The articles of incorporation of the Weld County association list the following purposes and powers:

"... To engage in any activity in connection with the protection of the health of any member of the Association or in the financing of any such activities, all in any capacity and on any co-operative basis that may be agreed upon.

"... To organize the several communities of Weld County into societies for the promotion of health and to aid in providing hospitalization of members; ..."

Medical-surgical plan - At present the members of some of the district units of the Weld County association are enrolling in the Colorado Medical Service through their district groups. The latter is a plan sponsored by the State Medical Society to provide for advance payment of bills for obstetrical care and for surgery performed in the doctor's office or in the hospital. At least half of the members of a district hospitalization unit must apply before the unit will be accepted for prepaid medical and surgical service. The annual dues for prepaid medical and surgical service are simply added to those for prepaid hospital service and paid through the office of the Weld County association. These dues amount to $9 for an individual, $18 for a subscriber and one dependent, and $24 for a family unit.

In neither the hospital nor the medical-surgical service plan does the Weld County association participate in control and management. The association has the same relationship to the two prepayment plans as does any other type of enrolled unit.

The bylaws of the county association provide for an annual membership meeting and election of officers. In general the duties of these officers are to explore possible ways to add to the health security of the members and to arrange for such services or other aids to health as the members wish. Arrangements for enrollment in Colorado's Blue Cross hospital service plan and in the Colorado Medical Service are two means adopted to attain these objectives.

By 1947 prepayment plans similar to Colorado Medical Service had been formed in 37 States. Additional organizations in other States are in the initial planning stage. Typically the plans providing surgical or other professional services during a period of hospitalization will not accept anyone who has not already subscribed to a prepaid hospital service plan. The two prepayment plans in some cases are operated through a single corporation. Whether or not the two plans are separately incorporated, the Blue Cross organization frequently administers both. In a few cases, however, the two are entirely separate corporations separately administered.

In 13 States besides Colorado, rural community enrollment is carried on through local organizations. A total of 37 plans reported some rural enrollment in 1947. Rural enrollment for the country as a whole in these plans which provide medical or surgical care in the hospital, however, is rather negligible. Of approximately 5 million subscribers enrolled early in 1947, it is estimated that only about 8 in 100 were rural.[3]

INSURANCE COMPANY PLANS

When a number of people run a common risk of loss - a risk that can be predicted for a group but not for an individual - one thing they can do is to insure themselves as a group against that common risk. This insurance principle lies behind the prepaid hospital service plan already discussed. It is also the basis of the various insurance plans to protect families against the large dent in their budgets that may be made by hospital or other costs resulting from illness or accident.

The insurance plans, however, follow conventional insurance practices. They reimburse a policyholder in cash for expenses covered by his policy instead of offering service benefits as does the typical prepaid hospital service plan under its subscriber contract. As the discussion of Blue Cross plans indicated, however, a number of these plans now make a cash allowance for the hospital room while continuing to provide other benefits in service.

Group enrollment is usually required in the insurance plans just as it is in the prepaid hospital service plans. A certain percentage of the members of an organized business or social group must apply before a group will be accepted. In addition, both types of organizations require the persons enrolled to make periodic payments in advance.

Commercial insurance companies are one source of group hospitalization insurance used by farmers' cooperatives. A large regional dairy association, for example, arranged with a commercial insurance company for the type of coverage its farmer-members wished. Under the plan agreed

[3]American Medical Association; Council on Medical Service. *Special Brochure No. 3. Medical Care Prepayment Plan Development.* Chicago, 15 pp. 1947. See page 15, "Figures reported from the sixty-five medical care plans show: 2. Thirty-seven plans entaged to some extent in rural enrollment. 3. Twenty-one of the thirty-seven plans reported 386,000 rural subscribers as of January 1, 1947."

upon, hospital insurance is available to members and employees of the association and also to employees of members. Family dependents as well as heads of households are covered. Under this arrangement 12,000 persons now have hospital insurance. Surgical insurance is also available but it is not carried by as large a number.

Other cooperative groups, like the dairy association cited, have arranged with commercial insurance companies for hospital coverage. Often special arrangements are made to better serve the wishes and needs of a co-op's members. Any group that gets protection through a commercial insurance company, however, has no voice in the company's operations beyond negotiating for group coverage.

Sometimes groups of people form their own insurance companies to meet their common need for protection against the high costs of care for a serious illness or accident. These companies usually are incorporated under mutual or other insurance laws which provide for member ownership, determination of policies, and control of business operations similar to that provided under the cooperative laws.

The Nebraska Farm Bureau Federation, for example, sponsored the organization of a hospital and surgical insurance company during 1945. Only Farm Bureau members and their families are eligible for membership and insurance protection inthis Nebraska company. In Ohio and Indiana, Farm Bureau sponsored insurance companies have offered hospital and surgical insurance to local farm bureau groups for a number of years. The Ohio company writes similar group coverage for local farm bureau units in Vermont, Maryland, Delaware, Connecticut, and Virginia.

The Grange Mutual Casualty Company of Ohio writes hospitalization insurance for members of Grange groups in the State. The National Farmers Union Life Association, through its "triangle" health insurance plan, offers hospital and surgical benefits along with other coverage in a single insurance "package." This insurance is available to members of local farmers union groups in more than a dozen States.

Group Health Mutual and Group Health Association

People who work with credit unions are in a good position to know how often the costs of a serious illness or accident lead a family into debt. During the late 1930's a group of Minnesota credit union leaders worked out the plan for Group Health Mutual of St. Paul. The company has consistently tried to apply cooperative principles of membership participation as fully as possible to its operations. Moreover, many hundreds of farm families have joined through their local co-ops. For these reasons, the plan of organization and operating methods of Group Health Mutual are discussed here.

Originally the founders of the mutual planned a single cooperative association. In this association prepayment for health services was to be combined with health education, preventive medicine, and improvement

of local health services and facilities where necessary. The group found that Minnesota had no single law broad enough to cover their objectives. As a result they formed two State-wide organizations: Group Health Mutual and Group Health Association.

The two organizations have identical membership and management. Group Health Mutual, incorporated in 1939 under the mutual health and accident insurance law, furnishes its members a prepayment system which helps budget the costs of hospital, medical, and surgical services. Group Health Association, incorporated at the same time under the social and charitable organization law, charters the local health units making up the membership of Group Health Mutual. It also carries on a health education program, chiefly through the bimonthly publication, "Group Health." In addition, it helps groups develop their own prepaid medical and hospital care plans to be carried out through local community clinics or hospitals.

Benefits - Group Health Mutual started by insuring only against the expense of hospital service. Later the company experimented with policies to protect its members against the total costs of hospitalized illness - including medical and surgical expenses as well as hospital costs. Its so-called "double-protection" policy, combining insurance against hospital bills with insurance against doctors' bills, was introduced in April 1946.

Within a few months, more than half the membership had changed to the new policy. By the end of 1947, nearly 9 out of 10 members of rural health units held double-protection policies. Because this coverage has proved so popular among members of farmers' cooperatives and among other groups as well, it is analyzed here in detail. In addition, the double-protection policy is included in the summary giving the principal features of three policies used by members of rural groups. (See table 1.)

The hospital service coverage under the double-protection policy provides an allowance of $4.25 per day toward hospital room and board, including regular nursing and dietary service, up to a limit of 30 days for any person covered during one year. Ten days are added to this limit for each year benefits are not used until the total equals 60 days. If the premium is paid annually in one lump sum, an additional 5 days are allowed. The contract provides benefits for hospitalization in any licensed or approved hospital within or outside the United States.

Hospital services covered up to a maximum of $50 for each of the groups listed include the following:

1. Use of operating room including anesthesia and transfusions.

2. X-ray of accident injuries.

3. Laboratory services.

Table 1. - *Principal features of policies used by members of rural groups enrolled in Group Health Mutual on large unit basis*

Type of policy[1]	Persons eligible for coverage	Initial fee	Monthly premiums[2]	Maximum benefits available to each person covered during each policy year		Waiting periods
				Hospitalization[3]	Other[4]	
"Double-protection" policy	Employed or self-employed person belonging to group of 20 or more chartered by Group Health Association as large unit; all dependents of such persons	$1 payable by head of household at time of application	Single male (employed)----------$1.75 Single female (employed)--------- 2.00 Husband and wife-- 3.00 Husband, wife and one child--------- 3.50 Husband, wife and 2 or 3 children--- 4.00 Husband, wife, and 4 or more children 4.50 Adult male dependent under 60---------- 1.75 Over 60--------- 2.25 Adult female dependent under 60---------- 2.00 Over 60--------- 2.50 (5)	1. Allowance of $4.25 per day toward room, board, and nursing care for 30 days during first policy year; increased by 10 days each succeeding year during which no claim is made up to maximum of 60 days. 2. $50 for each of following groups: a. Operating room, transfusions, anesthesia b. X-ray of accident injuries c. Laboratory services d. Drugs, dressings, intravenous injections, serums e. Oxygen, inhalations, diathermy, ultra violet and radiant heat treatments f. X-ray studies, basal metabolism, electrocardiograms 3. $15 for ambulance service to hospital.	1. Surgical care up to $200 for specific procedures as scheduled in policy 2. Maternity care ranging from $40 to $60 3. Treatment of fractures up to $100	Accidents-----None Illness requiring hospitalization----------15 days Surgical care------3 months Maternity care-----10 months
Hospitalization policy	Same as above	None	Single male (employed)--------$0.75 Single female (employed)-------- .75 Husband and wife-- 1.70 Husband and wife and all minor dependents-------- 2.10 Adult male dependent under 60---------- .85 Over 60----------1.00 Adult female dependent under 60---------- .85 Over 60--------- 1.25 (5)	1. Allowance of $4 per day toward room, board, and nursing care for 30 days during first policy year; increased by 10 days each succeeding year during which no claim is made up to maximun of 60 days; increased by 5 days in any one year if annual premium is paid in advance in lump sum 2. $40 for operating room, transfusions and anesthesia 3. $25 for each of following groups: a. X-ray of accident injuries b. Laboratory services c. Drugs, dressings, intravenous injections, serums d. Oxygen, inhalations, heat treatments e. X-ray studies, basal metabolisms, electrocardiograms 4. $15 for ambulance service to hospital	None	Accidents-----None Illness----15 days (for members of immediate family; 2 months for other dependent relatives dovered) Maternity cases----10 months
Personal physician policy	Employed or self-employed person belonging to group of 20 or more chartered by Group Health Association as large unit; all dependents except those more than 60 years or less than 1 year old (6)	$1 payable by head of household at time of application	Single person----- 1.00 Each of first two dependents-------- .75 Third dependent--- .50 Fourth and all other dependents combined .25	None	1. Surgical benefits as follows: a. Up to $150 for major surgery of head and chest including skull fractures b. Up to $100 for surgery of abdomen and limbs including pelvic and hip fractures c. Up to $25 for other fractures not mentioned above d. Up to $10 for minor surgery including that for tonsils and adenoids 2. Nonsurgical benefits as follows: a. Up to $75 for medical care of any kind after first $10 has been paid by member b. Up to $25 for consultation services of specialists after first $5 has been paid by member.	Accidents-----None Certain serious or chronic ailments as listed in policy----3 months Eye refractions and hernia---------12 months Maternity cases---------10 months

[1]The 'double-protection' policy is used by about 90 percent of the rural groups insured by Group Health Mutual; the remaining rural groups use the hospitalization policy. In addition a few rural families have taken out the personal physician medical-care policy. The other types of coverage offered by Group Health Mutual are not used by rural groups and, therefore, are not included in this table.

[2]Premiums are customarily paid in monthly installments. Quarterly, semiannual, or annual payment of premiums is made by some groups.

[3]Hospitalization benefits are reduced one-half to three-fourths for gynecological cases for dependent women and one-half for all maternity cases under both the double-protection and the hospitalization policy.

[4]Benefits other than hospitalization are reduced one-half for minor dependents under the double-protection policy.

[5]Adult dependents insured before the age of 60 are continued for full benefits beyond that age; otherwise they are entitled only to half benefits at a reduced premium rate.

[6]Infants are covered from birth if born under the coverage of the policy.

4. Special treatments including oxygen therapy, diathermy, ultraviolet and radiant heat treatments, and inhalations.

5. Electrocardiogram, basal metabolism, x-ray studies.

6. Drugs, dressings, serums, intravenous injections.

In addition a maximum of $15 is allowed for ambulance service to the hospital. Reimbursement for any of the listed hospital services is provided when services are received in a doctor's office in treatment of injuries resulting from an accident.

The doctors' bills covered include surgical bills ranging from $10 to $200 for various types of operations; costs of maternity care, not including prenatal care, from $40 to $60; and costs of setting fractures from $10 to $100. Doctors' bills up to these limits will be paid for surgery whether or not a patient requires hospitalization.

All policy contracts providing repayment to members for medical or surgical expenses state that the limits given in the policy schedule are not to be interpreted as the full fee for the type of care indicated. Rather they are the share of the medical or surgical fee that will be paid by the company. The remainder of the fee, if any, is payable by the insured.

Freedom of choice of physician is provided. A member policyholder will be repaid up to the limits stated in his policy for the costs of services performed by any licensed physician.

All members of a policyholder's family are entitled to equal benefits with the following exceptions: (1) hospital benefits for dependents are reduced one-half for maternity cases and from one-half to three-fourths for gynecological cases; (2) benefits for surgery and treatment of fractures are reduced one-half for minor dependents.

Group Health Mutual does not offer protection against the following: Cases requiring long-term institutional care including tuberculosis and mental, nervous, and psychological disorders; drug addiction and alcoholism; cases for which services are obtained in a hospital controlled by an agency of the Federal Government; rest cures, diagnostic work, or plastic surgery except when required to repair accidental injuries; cases compensable under the workmen's compensation act; treatment of injuries more than 60 days after an accident.

Following the effective date of the policy, benefits become payable immediately for accident cases. The waiting periods for other types of cases are 15 days for sickness; 3 months for surgery, and 10 months for maternity care.

With each policy providing hospital benefits, a member receives an identification card. The card has space for assignment of benefits to

a particular hospital in case the member wishes the mutual to pay the hospital direct up to the limits of its liability. If a member chooses to do this, he must assign his benefits as soon as conveniently possible after he enters a hospital and in any case not later than 2 days before leaving. The chief advantage in assigning hospital benefits is that to some extent it relieves the policyholder-member of the financial burden of paying his bills "out-of-pocket" before receiving repayment from the mutual.

If a member prefers not to assign his benefits to the hospital, he must first pay his bill in full and then send the receipted bill with his loss claim to the headquarters office of Group Health Mutual. When the claim has been received, the mutual will reimburse the member up to the limits stated in his policy. Whichever method a member chooses to use, he must submit a proof of loss claim within 90 days after the last day of his hospitalization.

Cost - Every person who wishes to join Group Health Mutual must first join Group Health Association. The dues in Group Health Association are $1 per year for each member family. In addition, each family that wishes double-protection coverage must pay a fee of $1 at the time the policy is taken out.

The amount of the dues or premiums for insurance in Group Health Mutual depends on the number of persons in a family. Usually member families pay their premiums in monthly installments. The following summary shows the monthly premiums for double-protection coverage for families of different sizes enrolled on a large unit basis. Large unit enrollment is explained in the next section.

Number of persons in family	Monthly premiums for members of large unit groups
Single employed male	$1.75
Single employed female	2.00
Husband and wife	3.00
Husband, wife, and one child	3.50
Husband, wife, and two or three children	4.00
Husband, wife, and four or more children	4.50
Adult dependent less than 60: Male	1.75
Adult dependent less than 60: Female	2.00
Adult dependent 60 or more: Male	2.25
Adult dependent 60 or more: Female	2.50

To be included in a family contract, a child must be under 21, unmarried, and living at home. Infants are accepted from birth. Dependent relatives living with the family who are more than 60 years old at the time of application for membership are eligible for half benefits at a premium rate of $1.25 per month. A policyholder's protection will be continued at a slightly increased rate after he retires.

Enrollment procedure - The members of any organization interested in joining Group Health Mutual must first be chartered by Group Health Association as a local health unit. To obtain a charter, the group must include at least 10 eligible employed or self-employed persons.

The members of business or social groups can join on either a large unit or a small unit basis. Under the small unit plan, not less than 10 employed or self-employed persons belonging to a preexisting group must enroll. The requirements for large unit enrollment are based on the size of a preexisting group. For groups of varying sizes they are as follows:

Number of eligible persons in preexisting group	Percentage of total eligible persons or number of applicants required for enrollment on a large unit basis
20 - 29 persons	100 percent or 27 applicants
30 - 49 persons	90 percent or 40 applicants
50 - 74 persons	80 percent or 53 applicants
75 - 99 persons	70 percent or 60 applicants
100 - 199 persons	60 percent or 100 applicants
200 - 299 persons	50 percent or 200 applicants
1,000 or more	40 percent or 1,000 applicants

There are no age restrictions for large unit enrollment. For small units, persons more than 60 years old are not eligible. In addition, conditions requiring hospital or doctor's care which exist before enrollment are covered in large unit but not in small unit groups.

Membership is open to individuals and a few persons, including a small number living in rural areas, have joined on this basis. Persons enrolled on an individual basis pays slightly higher dues than those paid by members of groups. A member policyholder who leaves the group with which he was originally enrolled can arrange to continue his insurance on an individual basis.

Enrollment of cooperatives - More Minnesota farmers belong to local cooperative creameries than to any other single type of cooperative in the State. In turn, local cooperative creameries are the largest single group of farmers' co-ops now enrolled in Group Health Association and Group Health Mutual. By the end of 1947, the member patrons of 165 local cooperative creameries had joined. Petroleum co-ops, rural credit unions, and cooperative stores in country towns are some of the other types of cooperatives through which farm families have enrolled. Altogether Group Health Mutual had insured the members of 341 groups by December 1947. Of these 205 were rural groups including about 75,000 members of farm families. Rural people represented three-fourths of the total enrollment at that time.

The first rural group to be enrolled on the large unit basis was the Almelund Creamery Company. The cooperative creamery group at Fergus Falls

with more than 1,000 persons covered is now one of the largest local health units. At the present time, the majority of rural members belong to large unit groups.

Activities of local cooperative health unit - Sometimes a cooperative's board of directors acts as the committee in charge of the health unit. Usually, however, a local health unit elects its own officers including a chairman, vice-chairman, and secretary-treasurer. The secretary-treasurer keeps membership records for the local group, receives and checks new membership applications, and collects dues.

An adaptation of the wage-deduction system is used to collect premiums from the local health units formed among the members of co-op creameries. Creamery patrons pay their insurance premiums through deductions from their milk or cream checks on a monthly basis just as industrial and business employees pay their premiums through deductions from their pay checks. For a cooperative creamery group to enroll, its board of directors must be willing to make cream-check deductions upon written authorization of its patrons.

To cover the costs of operation of a health unit, including the cost of sending delegates to district and annual membership meetings, each health unit receives an annual allowance from Group Health Mutual of 75 cents per person enrolled.

Membership meetings - The chairman of a local health unit calls a membership meeting at least once each year. At the regular annual meeting, members elect the officers of the local unit. They also elect delegates to represent the unit at the annual district and State-wide membership meetings held jointly by Group Health Association and Group Health Mutual. Matters of importance to the local unit which should be brought to the attention of district and State-wide meetings are discussed at the local meeting. Matters of general importance to Group Health Association and Group Health Mutual are also considered.

Each member has one vote on all matters that come up for voting at local meetings. He has the same voting privilege at district and State-wide membership meetings. He may cast his vote in person at any district or State-wide meeting he is able to attend. Otherwise his voting power is exercised through the delegates elected by the local unit to represent its members at district and State-wide meetings. The group of delegates elected by a local unit is assigned as many votes as there are member-policyholders in the local unit.

Farm families take an active part in the annual membership meetings of their local health units. Here they have an opportunity to suggest improvements in the services of the joint organizations as well as to vote for officers and delegates.

At district meetings and at the annual State-wide meetings, 20 percent of the members, present in person or represented by their elected delegates, constitute a quorum. At the annual State-wide meetings,

usually half or more of the members are either present or represented. Outside speakers, humorous skits, and movies are among the special features scheduled on these programs.

Board of directors - Candidates for the board of directors of the joint organizations are nominated at annual district meetings. Nomination by a district practically assures election at the State-wide annual meeting. Each of the six districts into which the State is divided is represented on the board in proportion to the number of members in the district. The board consists of 15 persons, each elected for a 2-year term. Their periods of service are scheduled so that the terms of 8 members end in one year and the terms of the other 7 end in alternate years.

The board of directors has general control of all business affairs including the adoption of rates and the development of application, policy, and other forms. The board also enacts necessary rules and regulations concerning the acceptance of risks.

The officers of the joint organizations are elected by the board from its own membership. They include the president, two vice presidents, and a secretary who also acts as secretary of the board. The board prescribes the duties of the officers to the extent that these duties are not limited or defined in the articles and bylaws. In addition, the board exercises all powers usually vested in a board of directors which are consistent with the articles of incorporation, the bylaws, and the laws of the State.

The executive committee, including the president, first and second vice presidents, secretary, and chairman of the board, may carry out such powers and duties of the board as the board authorizes. The bylaws require that the executive committee meet at least once each month. Customarily it meets between the bimonthly board meetings.

Management - A secretary-treasurer employed by the board is the active manager of the joint organizations. He is responsible for carrying out policies prescribed by the board, keeping the association's records, preparing reports, and handling all money collected and disbursed. He may not borrow money on behalf of the association or dispose of any of its securities, however, without express authority voted by the board.

Supervisory committee - As an additional measure to give the members supervision over the affairs of the organization, the bylaws provide for a supervisory committee of six members, each elected at the annual State-wide meeting for a 1-year term. No member of the supervisory committee may be a director or hold any other office in the association.

The supervisory committee is responsible for engaging a competent public accountant each year to audit the financial records. It then reports the findings to the members and the board of directors. The committee, itself, examines the records of meetings of members, directors, and all committees and presents a written report to the members at the annual meeting.

In order that the membership in different districts may be properly represented on the board of directors, the supervisory committee is required to know how members are distributed by districts. If it seems necessary, the committee must recommend revision of the districts. It must also determine, on the basis set forth in the bylaws, the number of directors to which each district will then be entitled and must report such new assignment of representation to the annual membership meeting.

Other functions of the supervisory committee include acting as a standing committee (1) to receive resolutions for consideration by the members and to present such resolutions, with or without recommendations, at the annual meeting; and (2) to receive and initiate amendments to the articles and bylaws and submit such proposed amendments, with or without recommendations, to the members by mail or in meetings.

Resolutions have been adopted by local health units and transmitted by the supervisory committee to the annual State-wide meeting to encourage quarterly, semiannual, or annual instead of monthly dues payments; to liberalize, if possible, the benefits under some of Group Health Mutual's policies; to endorse local public health units; and for other purposes. Bylaw changes proposed by the supervisory committee and adopted at annual State-wide meetings include amendments in regard to electing directors at large, changing the date of the annual meeting, and qualifications for board members.

COOPERATIVE HEALTH ASSOCIATIONS

Both the prepaid hospital service and the insurance plans already discussed help farm families make their health dollars go around. The typical rural health cooperative goes a step further by bringing needed health services into a rural community.

Farmers have long used cooperative methods to build grain elevators, feed mills, and cotton gins; to sell wheat, livestock, and eggs; to buy fertilizer, gasoline, and binder twine; to furnish themselves with fire insurance, irrigation water, and telephone service; in short, to overcome their handicaps as small, individual businessmen in a hundred and one ways. When they start using cooperative methods to solve their health problems, however, they enter little explored territory.

Available records show that organized health cooperation in this country has a distinctly rural origin. It started among a group of families living in Elk City, Okla., and the surrounding area. This group formed a cooperative health association in 1929. Two years later the association opened an 8-bed hospital and clinic. More than 10 years passed before a second rural group started a similar venture. Since 1940, however, cooperative associations in a dozen rural communities have started operating small health service centers.

A typical rural health cooperative has built, equipped, and arranged for doctors to staff a small hospital and clinic. The association has also worked out a budget plan under which its members can obtain prepaid

services at the health service center maintained by the co-op. Usually the membership is concentrated in one or two counties and adjacent territory. Membership is open to individual persons and families instead of being limited primarily to groups of persons belonging to existing business or social organizations. The members have a direct voice in the association's business management and in determining nonprofessional policies.

Four rural health cooperatives

Four pioneering rural health cooperatives have operated over periods of from 5 to 17 years. The services, costs, and operating methods of these four associations are summarized here since they typify the objectives of similar organizations formed more recently. The four associations include the Farmers Union Hospital Association, Elk City, Okla; Northwest Community Hospital Association, Mooreland, Okla.; South Plains Cooperative Hospital Association, Amherst, Tex.; and Achenbach Memorial Hospital Association, Hardtner, Kans.

The South Plains Cooperative obtained a charter in 1940. Thereafter it was determined that the Texas law did not provide for hospital associations formed by nonprofessional groups. It was, therefore, impossible to form additional hospital co-ops in the State.

Other rural communities, however, needed hospitals and other rural groups wanted to organize to get them. As a result the Texas Federation of Cooperatives, Farm Bureau, Grange, and other farm organizations worked together to get the State law changed. An amendment to the charitable corporation law was passed by the State legislature in 1945. The amended law specifically provides for rural cooperative hospitals. By the end of the year, 16 groups had obtained charters. Within 2 years, 9 new associations had opened small health service centers, each including a few hospital beds.

The other three rural health cooperatives are organized as nonprofit corporations without capital stock. Even though not incorporated under the cooperative laws, the associations keep their cooperative characteristics of one member one vote and membership participation in determining general policies.

Area served - The health service center of each of the four associations is located in a small rural trading center at the hub of several branching roads. The largest of the four communities has a population of 5,000. Each of the other three has less than 1,000.

More than nine-tenths of the land in the four areas is in farms. There is only one city of more than 10,000 within 50 miles of any of the four health service centers. There are about a half-dozen towns of between 5,000 and 10,000 within the same distance. Other trading centers in the four areas have a population of less than 5,000.

Facilities - A large share of the original building funds of the four associations was raised through the initial membership fee that all single individuals and families wishing to join are required to pay. Other sources of funds were voluntary contributions, bequests, and a Federal grant. In addition, volunteer labor furnished by individuals and organized groups helped reduce building costs.

Although the association which received a Federal grant maintains and operates its hospital on a cooperative basis, it does not own the hospital. One condition of the Federal grant was that the hospital remain the property of the community.

Three of the associations started with health service centers containing from 8 to 32 hospital beds. One started with no facilities except a doctor's office set up temporarily in rented quarters in the back of a drug store. (See figure 2.) As their membership grew, the cooperatives added to their facilities. They increased the number of beds in their health service centers, added to their equipment for diagnosis and treatment, and added to their space for doctors offices as more doctors proved to be needed.

The four health service centers now have from 32 to 85 hospital beds, nearly all in private or semi-private (2-bed) rooms. The largest of their wards has only 4 beds. In addition the centers house office space and examination and treatment rooms for from 3 to 7 doctors. Each center also has at least one operating room, a delivery room, laboratory, and drug room. Three of the associations have a nurse's home adjoining the health service center.

Staff - Amherst, Tex., had no doctor at the time the South Plains Cooperative Hospital Association was formed. The group "borrowed" a doctor from the staff of a cooperative hospital already in operation. After this doctor started to practice in an improvised office, the membership of the cooperative grew rapidly. Soon the doctor's office was transferred to the association's own health service center and a second doctor joined the first. The second man had formerly served on the staff of a private clinic. Later a third doctor, previously in Government service, visited the cooperative institution, became interested in its plan of operation, and decided to accept the association's offer of a position on the staff.

Doctors already practicing in the community formed part or all of the original staff of the other three health service centers. Advertising in medical journals has been one method used to find additional doctors. Occasionally doctors interested in cooperative plans write or visit an association to inquire about the possibility of securing a position on the staff of its health service center. In each of the cooperative centers, one doctor serves as chief of staff. All professional matters are left entirely to members of the professional staff.

Figure 2. - South Plains Cooperative Hospital, Amherst, Texas. The cooperative started with an improvised doctor's office in rented quarters.

A member of the association selects one staff physician as his "family doctor." Thereafter he goes to that doctor regularly for whatever care he needs. A member's chosen "family doctor" can freely call in other staff doctors for consultation in case the member develops an ailment that makes this desirable. He can also refer the patient to other staff doctors for treatment of a condition that might more appropriately be cared for by someone else on the staff.

The four cooperative associations have professional staffs ranging from one with two full-time and one part-time physician to another with seven full-time doctors including a dentist and specialists in surgery, urology, ear-nose-and-throat, gynecology and obstetrics, and internal medicine. (See figure 3.) The doctor who serves one association on a part-time basis maintains an office of his own in a nearby town. Each of the other two associations has three staff members. One has three physicians and the other has two physicians and a dentist. In general the associations try to maintain a staff large enough to care for the group demanding service including both members and nonmembers.

Maintenance of an open staff was one condition of the Federal grant that helped one association build a hospital. Members of each of the cooperative associations may have any outside doctor they wish attend them. They are responsible for payment of all fees that may be charged by an outside doctor, however, since the fees charged by doctors not on the staff of the cooperative institution are not covered by the cooperative prepayment plan.

The largest of the four hospitals employs a hospital librarian to keep clinical records. Each of the institutions has a pharmacist on duty in the drug department maintained for both hospital and clinic patients. Laboratory and x-ray technicians also serve each of the centers. (See figure 4.)

Three of the associations have a business manager. The fourth has no person so designated but the office assistant performs many of the duties of business manager and the secretary of the board of directors also takes on some of these duties.

Benefits - The prepayment plans of the four cooperatives are essentially plans for advance payment of doctors' bills. A co-op member doesn't need to be sick enough to require hospitalization in order to obtain prepaid service through the co-op's health service center. Each of the associations encourages its members to seek a doctor's care - provided on a prepaid basis - *before* an ailment becomes serious enough to require hospital care. They also encourage periodic physical check-ups - again provided on a prepaid basis. (See figure 5.) If a member requires hospitalization, however, the services of staff doctors are available to him on a fully prepaid basis during hospitalization just as they are when he comes to the doctor's office.

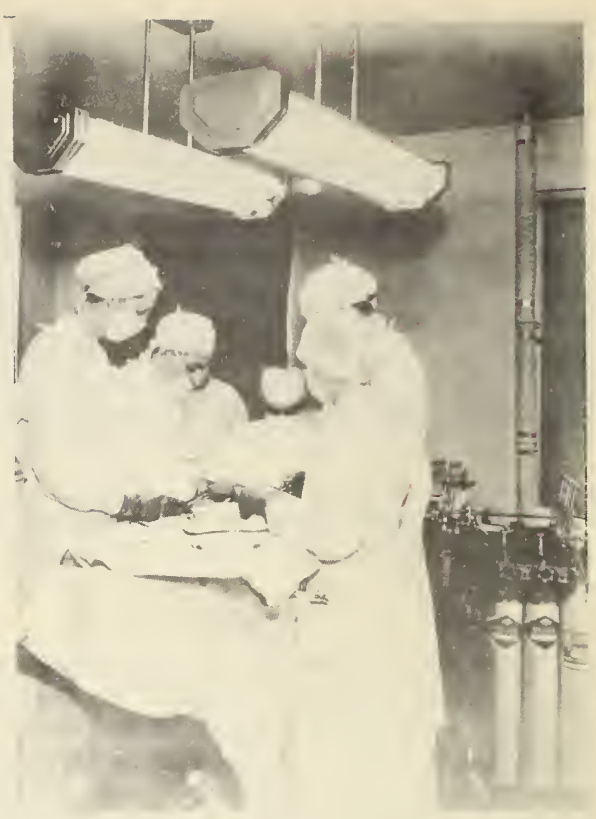

Figure 3. - The Farmers Union Hospital Association, Elk City, Okla., brought additional doctors, representing different specialties, into the area.

The services offered by the four associations on a fully or partially prepaid basis include the following:

1. Medical and surgical care in the doctor's office or in the hospital (fully prepaid).

2. Treatments and diagnostic tests (usually with extra charges to cover costs of materials; customarily charges range from 50 cents to about $3 for specific treatments and tests).

3. Hospital room and board including general nursing care at reduced rates (rates range from $2 to $5 per day).

4. Use of operating room, including anesthesia, at reduced rates (rates range from $10 to $24; one association, however, charges the rate prevailing in the community regardless of whether or not a patient is a member of the association).

In addition, dental care is among the partially prepaid services now offered by two associations. (See figure 6.) One association provides

dental care at a flat discount of 25 percent from customary charges for all types of dental service. The other has a schedule for specific dental procedures including extractions, fillings, and other treatment. One of the two remaining organizations has an office equipped for a dentist. Both plan to add dental care to their partially prepaid services when this becomes possible.

One association charges members $1 for calls during the day and $2 for calls at night. Another charges members $1.50 for each home call. The two associations make additional mileage charges of 20 cents and 25 cents per mile, respectively. Neither of the other organizations makes any reduction to members in the cost of home calls.

Figure 4. - Laboratoty services are among the essential services provided by the four cooperative hospitals.

The four prepayment plans do not cover the costs of medicines and drugs. In general the charges for drugs obtained at an association's drug store are the same as those elsewhere. The quality of the drugs sold through an association's drug store, however, can be controlled by the cooperative.

Figure 5. - Periodic check-ups are part of the prepaid benefits offered by the four cooperative hospital associations. Here a youngster gets a physical check-up while her mother watches.

All services obtained by members from non-staff doctors or from other clinics or hospitals are excluded from the services offered under the cooperative prepayment plan. Each of the cooperative associations provides service under its prepayment plan only through its own staff and health service center.

The obligation of each or the cooperatives to members is limited to the extent of its ability to serve them through its own health service center. If diagnosis indicates that adequate treatment of a case cannot be provided with the facilities and staff at the

disposal of the association, the association's responsibility is discharged when advice has been given as to where treatment can be obtained.

Figure 6. - A dentist serves on the staff of two of the cooperatives.

Like most other types of prepayment plans, the cooperative associations exclude from prepaid services long-term illnesses such as tuberculosis, mental and nervous diseases, chronic alcoholism, and drug addiction. Cases for which compensation is available under the workmen's compensation laws will not be treated on a prepaid basis. In general, conditions requiring medical or surgical care that exist before a member joins an association are not covered by the prepayment plan. One association modifies the restriction against preexisting conditions by barring from prepaid service only those conditions requiring major surgery; another bars such conditions if they are "serious." Maternity care is excluded from prepaid services for the first 10 to 12 months.

The fact that conditions existing prior to membership are not covered by the prepayment plan does not mean that they will not be cared for. Members can obtain service for such conditions just as for any other. They must pay the same fees as nonmembers for these services, however.

One of the associations publishes a monthly bulletin for its members. The bulletin carries news about the association and also short articles on health subjects.

Cost - Any person or family wishing to join one of the four cooperative health service associations must first pay an initial membership fee of $50. This fee goes into the association's fund for building and equipment. The only exception is the organization which set the initial fee for its first 1,000 members at $25 since a large share of its original building funds came from the bequest of a wealthy farmer. (See figure 7.)

Most of the rural health cooperatives organized during the last few years charge from $75 to $125 for the initial membership fee. The present greatly increased costs of construction make the higher fee necessary.

Payment of the initial fee entitles a person to a membership certificate under which he and his dependents, as named in the certificate, become eligible for prepaid services in return for regular advance payment of

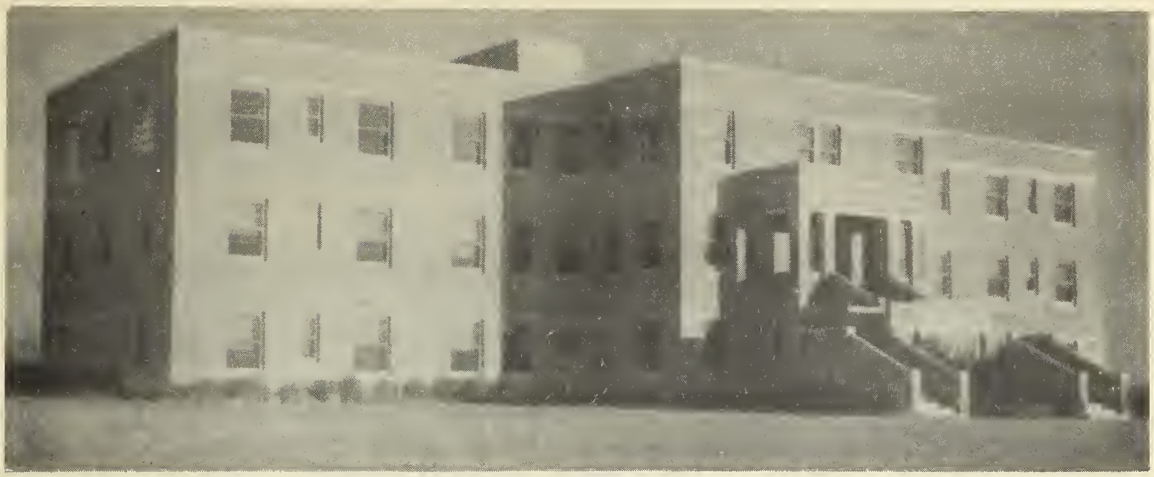

Figure 7. - The bequest of a wealthy farmer helped the Achenbach Memorial Hospital Association finance the building of this hospital.

annual dues. The annual dues charged by each of the associations vary somewhat from those of the other three. The range in the annual dues scheduled by the four associations for families of different sizes is as follows:

Size of family unit	Range in amount of annual dues charged by the four associations
1 person	From $12 to $16
2 persons	From $18 to $24
3 persons	From $22 to $30
4 persons	From $25 to $35

Each of the associations defines a family unit as father, mother, and unmarried children living at home regardless of age. Two associations charge the same amount of annual dues for any family of four or more persons. Two make an additional charge of $1 or $2 for each additional member of the immediate family beyond four persons. All four associations make an additional charge of from $6 to $8 for each related family dependent living under the same roof who is not a member of the immediate family.

The annual dues represent the cost to the association of the prepaid services performed for members. They do not, as a rule, cover the entire cost to the member of all the services he requires during any year. As the preceding section dealing with services offered by the four associations explained, the costs of services performed by staff doctors in the doctor's office or in the hospital are fully prepaid. In addition, each association makes more or less limited allowances to its members for hospitalization and various special diagnostic and treatment procedures.

The actual operating costs of the four cooperative institutions, like those of similar institutions operated on a noncooperative basis, are

subject to change as economic conditions change. The associations provide in their bylaws for adjustments in the annual dues and other charges to meet general economic changes. At the annual meeting of one association 2 years ago, the members voted to make such an adjustment. The annual dues were increased approximately one-third in order to meet the higher costs of maintaining service under present conditions.

Enrollment Procedure - Unlike the typical procedure in prepaid hospital service and insurance plans, the cooperatives do not require enrollment through existing business or social organizations. Any individual or head of a household may submit an application for membership on the form provided by the association. Before his membership becomes effective, his application must be approved by the board of directors and the initial membership fee must be paid. In addition, two associations require a signed statement by the applicant concerning his own health and that of his family dependents. The other two associations require a physical examination of all applicants and their dependents before admission to membership. Few persons are kept from joining because of an existing ailment. Care for such ailments, however, particularly those that require extended medical treatment or surgery, usually is not furnished under the prepayment plan.

To start out, each of the health service co-ops has built up as large a membership as possible. The initial fees paid by this group provide the chief source of funds for the facilities and equipment needed to make health services available. In addition, the members who pay their dues annually in advance provide an association assured financial support over the years.

Membership - Two of the associations report that approximately nine out of 10 of their member families live on farms. The other two report that about three-fourths of their members live on farms.

The membership of one organization is concentrated within a rather limited area. An estimated nine out of 10 members come from within 35 miles of the association's hospital center. Even in this association, however, a few members come from distances as great as 100 miles or more. Another association draws about half of its membership from within 35 miles of its health service center, but nearly one-third come from distances greater than 50 miles. The managers of the other two associations estimate that 80 to 90 percent of their members come from within less than 50 miles of the hospital center and the remainder from distances of 50 to 150 miles.

Each of the associations reserves the right to limit the membership to any number beyond the total enrolled at the time. During recent years, shortages of building materials, scarcities of clinic and hospital equipment, and shortages of doctors, nurses, and other personnel have made it impossible for the associations to expand their facilities or their staffs. As a result, any great expansion of their membership has not been advisable. Nevertheless, a few new members have been added

from year to year. Sometimes a nonmember applies for membership after receiving service in the clinic or hospital. Sometimes the marriage of a young man or woman previously included in the parents' membership results in an application to cover the new family unit. Occasionally a new family in the community applies for membership.

Although placing a rather close limitation on the membership may be necessary for a temporary period, it obviously might lead an association into disaster if carried on indefinitely. An association needs to take in younger people in order to keep its membership a representative group as far as age is concerned. Unless an association does this, sooner or later it will be faced with the increasing demands for service made by an aging membership. Over a period of years increased demands for service could lead to mounting costs and the need for increasing the annual dues, reducing the prepaid benefits, or other measures to maintain solvency.

The active dues-paying membership of the four associations now totals about 4,500 families. Nearly 16,800 persons, including heads of households and family dependents, are eligible for the prepaid benefits provided by the four cooperative health service centers.

The board of directors has the right to purchase the full interest of any member if this is considered necessary or desirable in order to serve the best interests of the association. A membership may also be transferred to another individual or family upon payment of the required fee, provided the board of directors approves the transfer.

Membership Meetings - The members control general policies and business management of the associations chiefly through the annual membership meetings. At these meetings directors are elected, bylaws may be amended, and other business is transacted. The elected board of directors is charged with general supervision of an association's business affairs. (See figure 8.)

Special meetings of members may be called at any time by the president of the association or by a majority of the board of directors, according to the bylaws of three of the associations. The fourth provides that the president or secretary call special membership meetings. Two associations make it the duty of the directors to call a special membership meeting upon receiving a petition for such a meeting signed by at least 20 percent of the members. One association stipulates that notice carried in the official bulletin of the association, which is sent to all members, constitutes official notice of annual or special membership meetings. The other three provide that written notice must be mailed to each member by the secretary at least 10 days prior to any membership meeting. A quorum at membership meetings is variously defined by the associations as (1) the members present in person, (2) 50 members present in person, and (3) 5 percent of the members.

At least one association makes its annual membership meeting an all-day affair. After the official reports, election of officers, and other business, outstanding leaders in the fields of health and cooperation appear on the program.

Figure 8. - The directors are "keymen" in a rural health cooperative. Here some of the board members of the Northwest Community Hospital Association, Mooreland, Okla., meet with the hospital administrator.

Service to nonmembers - The four cooperative institutions make no distinction between members and nonmembers in furnishing medical, surgical, and hospital services. The members who make regular advance payment of dues, however, are the only persons entitled to service on a fully or partially prepaid basis. Nonmembers must pay regular fees for service at the rates prevailing in the area. The income from fees paid by nonmembers is allocated to professional and other workers and to hospital and clinic maintenance. The associations report that nonmembers make up about one-third to two-thirds of the hospital patients and about one-third to one-half of the clinic patients.

SUGGESTIONS FOR RURAL HEALTH IMPROVEMENT PROGRAMS

The preceding sections of this report have pointed out some of the steps by farmers' cooperatives to improve the health situtaion of their members and the areas where their members live. In many rural areas, however, little has yet been done. In some, local health problems have been considered at meetings of co-ops and other organizations. They have also been discussed in local newspapers, co-op papers, and other publications.

Talking, reading, and thinking about a problem sooner or later lead to a desire to do something about it. Then the questions are: *What to do?* and *How to do it?* This is the point at which the members of many cooperatives and other local farm organizations now find themselves. An outline for health study and planning follows this section of the report. The outline suggests in considerable detail how local groups might proceed in deciding the "what" and the "how" for improvement of their local health situation.

PRE-PLANNING STUDY

In many ways a pre-planning study with health improvement as the goal is like a pre-organization survey for a cooperative association. Members of farmers' co-ops know that a successful co-op doesn't just happen. Sometimes months of careful study of an area and its needs are required, often followed by additional months of careful planning.

If a dairy co-op is proposed, for example, a representative group of dairy farmers gets together to study their area. Usually they call in marketing experts and perhaps other experts as well to advise and assist them. They look into the volume of business available and the probable volume that a co-op might expect to attract. They also look into the ways required services are now being performed. If additional facilities seem to be needed, they carefully investigate the area's financial resources for building and maintaining new facilities. Finally they size up the situation and decide whether or not it is practicable or desirable to form a cooperative. If improvement of an area's health situation is the objective, careful study is again required as a basis for sound planning.

Area to be considered

Farm families usually go to the nearest main trading center for household and farm supplies and services beyond their day-to-day requirements. These include medical, dental, and hospital services. As a result, more doctors and dentists usually are located at this trading center than elsewhere in the area. If the area has a single hospital, it is also usually located at the main trading center. For these reasons this center is a logical starting point in deciding what area to include in local health study and planning. Probably the boundaries of its trading area will coincide with those of a logical area for health study and planning.

The distances farm families travel to reach the main trading center fix the boundaries of the main trading area. These boundaries may lie 40 or 50 miles from the main center. They may, on the other hand, extend no more than 20 or 25 miles away, depending on the size and concentration of the area's population, condition of roads, and other factors. Several smaller centers, each with its own trading territory, may be found within the main trading area.

Political boundaries such as township, county, or even State lines are not important in fixing the boundaries of a trading area. They can also be ignored in determining the size of a logical area for health study and planning. Certain facts that a study group will need to know, however, such as the number of people living in the area as a whole and in its different parts, usually are published for county or other political units. For this reason a local group may find it practical to rely on facts easily obtained, keeping in mind that the area with which they are actually concerned may not coincide exactly with the area for which facts are easy to find.

In most States the agency charged with administering the Federal hospital law has mapped out logical areas for making hospital service available to everyone in the State. Local groups can find out from this agency - usually the State health department - how their part of the State fits into the over-all State plan. This information may help them in charting the area for local study.

Groups to be represented

In planning for health improvement, more is at stake than the interests of a single group in an area. Obviously, health problems and needs cross all the economic and social barriers that separate different groups living in an area from each other. A communicable disease in one family endangers other families - not just the neighbors next door or down the road but those the family meets in town on Saturday or in church on Sunday, who belong to the same business or social organizations, whose children attend the same school.

The economic loss from serious disability caused by illness or accident also goes beyond the family immediately concerned. Part of their purchasing power for ordinary family needs is lost because bills must be paid for the care needed to restore health. If the head of a family is stricken, his loss of earning power results in a further loss of family purchasing power. His inability to work and thus contribute his share to the community's economic life adds still more to the economic loss of the whole community. Sometimes a family becomes dependent on the rest of the community for support as a result of the permanent disability or death of the head of the household.

In addition to these hazards to health and economic stability which are shared by all the people in the community, everyone is also personally affected by a local shortage of health services regardless of the fact that some can afford to go outside the area for any services they need. In an emergency, having to go some distance for service may seriously jeopardize a person's health. Even though he foresees this possibility, the average individual can do little by himself to remedy the situation.

Since all groups share a common interest in an area's health problems, it is logical and essential that all groups be represented in health study and planning. If they do not work together to support the highest health standards possible for their area, they will inevitably share the economic and social costs of failure to meet this standard.

DEVELOPING AND CARRYING OUT PROJECTS

Careful study of an area's health situation will provide a fund of information about the area's population, hospitals, doctors, customary use of health services, resources to support service, and related facts. With this information to draw upon, plans can be made to fill in gaps in local services. The steps rural groups in other areas have taken will offer suggestions for local projects. No comprehensive blueprint for local health improvement has yet been drawn, however, which can be applied without change to rural areas everywhere. Local groups will find many sources of information and assistance available. In the end, they, themselves, must draw a blueprint to fit their local situation.

Many projects may be suggested. Some may go far toward meeting the total health needs of an area. Others may attack the problem from only

one angle. All the suggested projects will need to be judged by what they can be expected to accomplish in building better individual and community health and by their feasibility in view of the area's situation and its financial resources.

Some projects probably will be developed to meet specific, short-term objectives. A short, snappy campaign carried out by a special temporary committee can prove effective in carrying out a project of this kind. Such a campaign has a special appeal. It is spectacular and it gets quick results.

The job of building and maintaining good health in a rural area, however, is more than a one-time, short-term venture. Changing conditions are likely to bring changes in need. Moreover, in the field of health services, as in all fields in which rapid scientific progress is being made, a situation ideal at one time may rather quickly become outmoded.

Because the health picture is ever-changing, study and planning for an area's health needs might well be looked upon as a continuing process. A council representative of all groups and organizations in an area might be set up as a permanent organization. Its job would be to keep informed about changes and to propose adjustments in facilities or services that seem desirable or necessary from time to time. While organized on a permanent basis, the council's membership might change periodically as new representatives are elected or appointed from its member organizations. This would help the council to reflect at all times the current thinking of the area.

PLANNING FOR A HEALTH CO-OP

In many rural areas, cooperative associations have long helped farm families meet special needs. In such areas, thinking about the possibilities of a cooperative health association may be the natural outcome of study and planning for health improvement.

If forming a health cooperative is finally agreed upon, a working group, representative of the whole area, should be chosen to draw up basic plans. Lawyers, architects, contractors, doctors, county agricultural agents, public health workers, and others with special training or experience can help the group with many specific problems.

Often when a new co-op is under consideration, emphasis is placed on possible dollar savings. The prepayment plan of a health cooperative can, of course, offer a family a measure of protection against extremely large bills at any one time. Possible savings in dollar outlay for service, however, seem less important than other possible advantages of a health cooperative.

Typically a rural health cooperative protects family and community health by arranging for more complete service in areas where existing service is deficient or lacking. It further safeguards health by

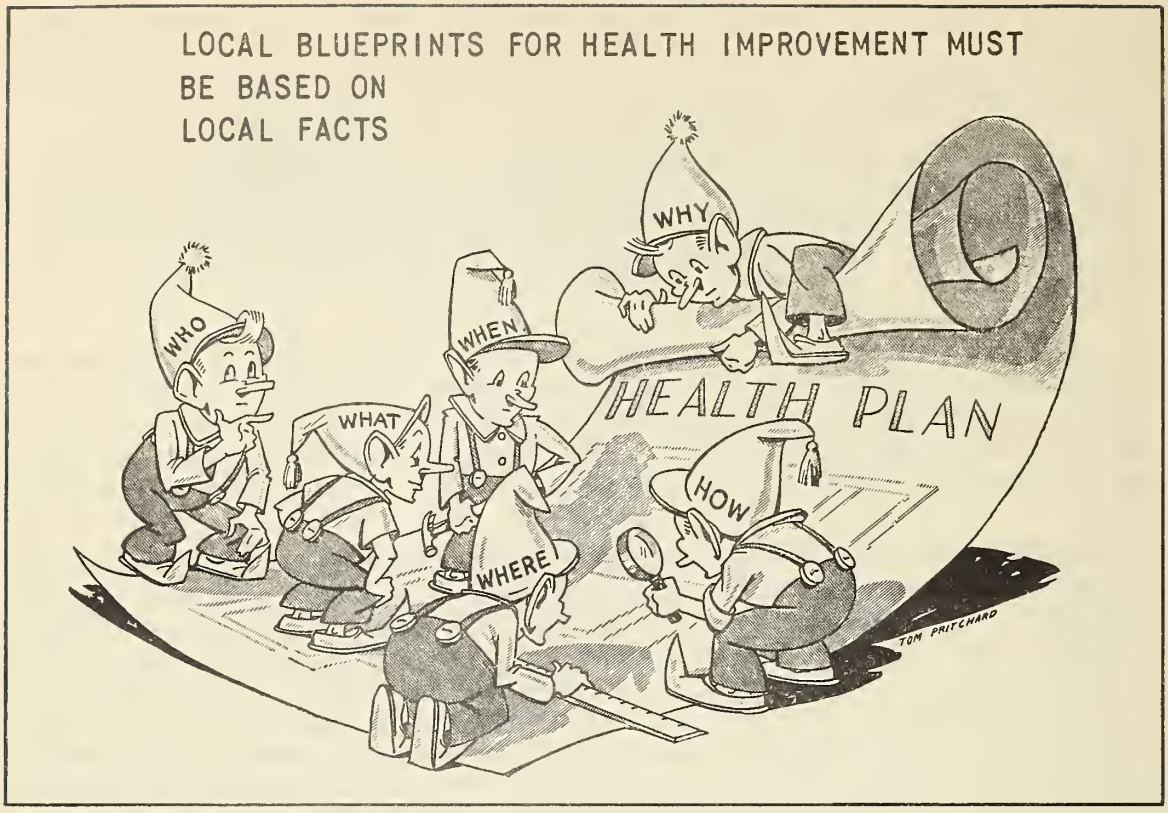

Figure 9. - There are no comprehensive blueprints for local health improvement applicable to all areas. A local group must first get and appraise the facts, then plan according to specifications based on the facts.

encouraging use of service to maintain health - not just to cure sickness. The value of a cooperative as health protection is hard to measure. Protection of family and community health, however, may well be the most important contribution a health cooperative can offer.

Some groups, such as the four rural health cooperatives described in this report, have successfully taken pioneering steps in establishing cooperative health associations. Nevertheless, the field is still new. As in other new fields, there are many problems simply because of the newness of the idea. In addition, the field of health cooperation presents special problems. In some States, lack of a satisfactory law under which a group can incorporate presents an obstacle that so far has proved insurmountable. Even after groups have incorporated, the high cost of building and equipping a clinic or hospital sometimes has been a stumbling block. Moreover, cooperative groups in some cases have found it extremely difficult to secure doctors and to develop mutually satisfactory working agreements with them. This problem arises partly from the current shortage of doctors - a shortage most acute in rural areas. It also arises from misunderstanding and disagreement between professional and cooperative groups.

Gradually these problems are being worked out. Texas and Wisconsin are two States in which certain legal restrictions have recently been removed. In these and other States, the same groups of farmers who once got together to organize and finance a business service co-op are now in some communities joining with rural townspeople to build a cooperative clinic or hospital. As groups of medical leaders meet with cooperative leaders to lay the foundation for mutual understanding and cooperation, barriers to effective working relationships between these two groups are also being broken down.

GENERAL APPLICATION OF COOPERATIVE PRINCIPLE

Cooperation is said to have started when it was first discovered that two men could roll a heavier stone or lift a heavier log than one man could alone. The health problem in many rural areas today requires full application of teamwork principles whether or not a cooperative health association is formed. Only by teamwork among doctors and laymen and among farmers and rural townspeople can a rural area's health problems be solved in a satisfactory way.

Rural families, like families everywhere, have long been used to paying for sickness. A well-rounded health program can provide a chance to invest in health. To many people, investing in health is a new idea. The question, "What will it cost?" must, of course, be answered. Another equally important question is, "What dividends in improved living and greater prosperity will an investment in health return to us as individuals and as members of our community?"

APPENDIX

OUTLINE FOR HEALTH STUDY AND PLANNING

I. DECIDE WHAT AREA TO INCLUDE

A. Consider main trading area

The main trading center of an area is likely to be its chief medical and hospital center as well. So, it is probable that a logical area for health study and planning will coincide with the main trading area. The distances farm families customarily travel to reach the main trading center fix the boundaries of its trading area. Among the factors which affect a trading area's size are:

1. Number of people in the area
2. Extent to which people are concentrated or scattered
3. Highways and other roads
4. Barriers to travel such as rivers, lakes, or mountains
5. Public transportation
6. Telephone service or other means of communication

B. Consider area for which information can be easily obtained

While political boundaries such as township, county, or even State lines are not important in fixing the boundaries of a trading area or of a logical area for health study and planning, certain information about an area that a study group will need usually is published for county or other political units. A local group may find it practical to rely on facts that can be easily obtained, keeping in mind that the area with which they are actually concerned may not coincide exactly with the area for which facts are easy to find.

C. Consider hospital service areas set up by State agency

Not all areas, of course, need a hospital located within their borders since some are served by nearby hospitals. Recently the State health department or some other agency in nearly every State has mapped out logical areas for making hospital service available to everyone in the State. Information from this State agency as to how their part of the State fits in the overall State hospital plan may help a local group in deciding upon the area for local study.

II. ORGANIZE A HEALTH STUDY AND PLANNING COUNCIL

Securing cooperation among all groups concerned is the best way to reach a satisfactory solution to any problem. Since all groups living in an area are concerned with the area's health problems, to the fullest extent possible all groups should be represented in an area-wide health study and planning council. Among the groups to be included are:

A. Farm organizations

1. General farm organizations such as Farm Bureau, Farmers Union, and Grange
2. Cooperatives, including marketing and purchasing co-ops, rural electrification associations, production credit associations, and others
3. 4-H Clubs, FFA, junior groups of farm organizations, and other youth groups
4. Extension clubs and home demonstration clubs

B. Professional organizations in the health field

1. Medical society, dental society, and nurses' organization
2. Hospital association
3. Local public health unit
4. Red Cross, tuberculosis association, and other local voluntary health agencies

C. Business men's groups

1. Chamber of commerce
2. Rotary Club, Lions Club, or similar organizations
3. Bankers' association

D. Other community organizations

1. Churches
2. Parent-teacher associations
3. School board
4. Local lodges

III. GET THE FACTS ABOUT THE AREA

A. Organize council for fact-finding

Within the health study and planning council, special committees and subcommittees may be set up to investigate the health situation in particular communities or county areas. Or they may be set up to study special aspects of the situation in the area as a whole.

B. Set time limit for study

Perhaps 3 or 4 weeks may be allotted for fact-finding. During this period each committee or subcommittee may hold several meetings to prepare a report for presenting to the whole council at the end of the allotted time.

C. Look for sources of information and assistance

Among possible sources are:

1. County and other local officials
2. County agent and home demonstration leader
3. Local public health officials, medical societies, and hospital administrators
4. Local chambers of commerce and businessmen's records
5. Local organizations including cooperatives, general farm organizations, church groups, parent-teacher associations, and others
6. Local libraries and the State library
7. State Health Department, State University, State Extension Service, and other State offices

D. Gather and summarize facts needed in order to make a sound appraisal of the area's health situation

1. General characteristics of area

Large-scale maps might be prepared to show general characteristics of the area, such as the following, that affect need for health services and are also important in determining the location of health service centers.

a. Population centers

In mapping an area, one symbol might be used for cities and towns with less than 2,500 people, another for those with 2,500 to 10,000 people, and still another for those with more than 10,000 people.

b. Roads

U. S. highways, State highways, other all-weather roads, and roads of other types.

c. Barriers to travel

Rivers, lakes, mountains, or other barriers to travel within the area or to and from the area.

d. Public transportation

Bus, train, and other public transportation routes within the area and to and from the area.

2. Population

a. Distribution now and 10 years ago

Again maps might be prepared showing:

(1) Number of persons per square mile for each county in area as shown by most recent census reports.

(2) Number of persons per square mile for each county in area 10 years earlier

b. Seasonal and long-term changes

(1) Approximately how many persons come into area regularly each year as seasonal workers or vacation seekers?

(2) What is the present total population of the area?
What was the population 10 years ago?
What was it 20 years ago?
What change in population seems likely to occur during the next 10 to 20 years?

c. Age

(1) Approximately how many persons in area are in following age groups as shown by recent census reports:
(a) Less than 1 year old?
(b) From 1 to 14?
(c) From 15 to 44?
How many women are in this group?
(d) From 45 to 64?
(e) More than 64?

3. Health resources of area

a. Hospitals

(1) Show on map location of general hospitals within area and nearby. Indicate by use of special symbols which hospitals are approved by the American Medical Association, American College of Surgeons, or some other recognized agency. Also indicate by special symbols hospitals which have been closed within the last 5 or 10 years.

(2) List hospitals in area showing:

(a) Number of beds each hospital was built to contain.

(b) Number of beds in each hospital occupied on an average day. Usually the hospital administrator can furnish the total number of days spent by patients in the hospital during the past year. This figure divided by 365 gives the number of beds occupied on an average day.

(3) Indicate what sections of the area have ambulance service available.

b. Doctors, dentists, and nurses

(1) List places in area at which doctors are located showing how many general practitioners, dentists, and surgeons or other specialists with specialty board certification are in active, full-time practice in each place.

(2) List doctors, dentists, and specialists who have come into or returned to the area during the last 5 to 10 years.

(3) List doctors, dentists, and specialists who have left the area during the last 5 to 10 years. If possible, give reasons for their leaving.

(4) List registered nurses available for active nursing duty and places where they are located.

(5) List other persons with special training who practice in the area.

c. Public and voluntary health agencies

(1) List all services of public health agencies available to people in the area and indicate the nearest centers at which services can be obtained. These might include such services as control measures for tuberculosis or other communicable diseases, laboratory services, school health services, services for crippled children, and others.

(2) List available services of voluntary health agencies and nearest centers at which services of each can be obtained. Such agencies as the Red Cross, Tuberculosis Association, American Cancer Society, and others might be included.

4. Customary family use of personal health services

Obviously it is important to know not only what personal health services are available to an area but also what use is customarily made of these services by families living in the area.

Probably it will be impracticable, if not impossible, to get reports from all families in an area concerning their use of personal health services. Reasonable estimates might be obtained by circulating questionnaires to all members of interested organizations. Or, through the cooperation of local editors, a list of questions might be printed in county newspapers with the request that they be answered and returned to the health study and planning council. Of course, no signatures would be required on the lists returned.

Answers to questions such as the following will be useful to a health study and planning council in trying to size up customary family use of personal health services:

a. *Total use of health services*

How many families:

(1) Used no personal health services during the past year?

(2) Went to a family doctor?
How many visits were made?

(3) Went to a specialist?
How many visits were made?

(4) Went to a dentist?
How many visits were made?

(5) Went to a hospital?
How many days were spent in the hospital?

b. *Use of services within area*

How many families obtained all health services during the past year from within the area?

c. *Use of services outside area*

How many families went outside the area for:

(1) All health services used?

(2) Care furnished by a family doctor?

(3) Care furnished by surgeons or other specialists?

(4) Dental care?

(5) Hospital care?

(6) Other services?

d. *Reasons for going outside area for service*

How many families went outside the area for service because:

(1) They preferred a certain doctor or dentist?

(2) They preferred a certain hospital?

(3) They were advised by their family doctor to go outside the area?

(4) The services needed were not available within the area?

(5) For other reasons?

e. Reasons for delay in seeking service

How many families delayed seeking medical, dental, or other professional services because:

(1) Of the distance to be traveled?

(2) They feared the possible expense?

(3) For other reasons?

How many families delayed going to a hospital because:

(1) Of the distance to be traveled?

(2) They feared the possible expense?

(3) For other reasons?

5. Sources of local support for personal health services

a. Payments for service made by individual families

Typically the payments for service made by individual families are the most important source of support for local health services. Probably an estimate of what families in the area pay for health services can be obtained by including questions concerning payment with those concerning use of personal health services.

(1) How many families had no expense for personal health services during the past year?

(2) How many families spent:
Less than $10?
More than $10 but less than $50?
More than $50 but less than $100?
More than $100 but less than $200?
More than $200?

b. Participation in insurance or prepaid service plans

Contributions from insurance and prepaid service plans are another source of support for health services and facilities. So, it is important to find

out how many families in the area are enrolled in plans of various types. It is also important to find out why some families have failed to join plans operating in the area.

(1) How many families have insurance either as individuals or through groups of which they are members:
Covering health and accident?
Covering hospitalization?
Covering medical or surgical expense?
Covering other costs of sickness or accidents?

(2) How many families belong to:
A Blue Cross group?
A group enrolled in a medical-society sponsored medical-surgical plan?
A health cooperative?
Some other prepayment plan?

(3) How many families have failed to subscribe to insurance or prepaid service plans operating in the area because:
It costs too much?
It doesn't cover the services believed to be most needed?
The family doesn't belong to an eligible group?
The family has neglected to join?
Hospitals are too far away?
For other reasons?

c. *Annual family income*

Annual family payments for health service indicate how much families have been *willing* to pay for health services. Annual family income is a measure of what families are *able* to pay. Information about annual family income probably can be obtained from county or State officials, local chambers of commerce, local bankers, or other sources.

(1) How many families in the area have an annual cash income of:
Less than $1,000?
$1,000 or more but less than $2,000?
$2,000 or more but less than $3,000?
$3,000 or more but less than $4,000?
$4,000 or more but less than $5,000?
$5,000 or more?

d. Total annual income of area

The total income of an area from all sources shows the ability of the area as a whole to support health services. Periodic census reports give income figures by counties. Reports of the area's total income may also be available from local records of county officials or chambers of commerce.

(1) What was the total income of the area from all sources during the most recent year for which figures can be obtained?

(2) What was the total income of the area from agriculture during that year?

(3) What has been the area's annual average income over the most recent 10-year period for which figures can be obtained?

(4) What was the highest total income in the area during the last 10 years? During the last 20 years?

What was the lowest total income in the area during the last 10 years? During the last 20 years?

IV. APPRAISE AREA'S SITUATION

When its fact-finding has been completed, the health study and planning council can look at its maps and tables and size up the area's situation.

A. Measure resources for personal health service by adequacy to meet needs and to meet recognized standards

1. How far must people travel to reach the nearest:
   Doctor?
   Dentist?
   Hospital?

2. Over what kind of roads must people travel?

   How long is it likely to take at different seasons of the year?

3. Is ambulance service available throughout the area?

4. How many persons, on the average, must each general practitioner in active, full-time practice take care of?

Of course, the number of doctors needed varies somewhat from one area to another. It depends not only on the number of people in an area but also on how much use people ordinarily make of a doctor's services and other factors. A local group, however, can compare the average number of persons each local doctor serves

a. With the basic standard of one doctor for every 1,500 persons;[1]

b. With the standard of at least one general practitioner for every 1,200 persons.[2]

5. How many beds in general hospitals are there for every 1,000 persons living in the area?

How many beds for every 1,000 persons are there in general hospitals approved by the American Medical Association, the American College of Surgeons, or some other recognized agency?

How does the number of beds in *approved* hospitals compare with the recommended standard of 2-1/2 to 3-1/2 beds per 1,000 persons for rural areas?[3]

6. Persons in the very young and very old age groups and women of child-bearing age have greater need for health service, on the average, than other persons. When the proportion of persons in the area in these groups is compared with the proportion for the State as a whole, does the area show a greater or lesser need for health services than the average for the State?

7. Is the number of seasonal workers or vacation-seekers coming into the area at certain seasons large enough to make any real difference in the number of doctors or hospital beds needed in the area?

8. Over the past 10 to 20 years, has the population of the area grown or become smaller? If change in population continues at about the same rate, will a greater or smaller number of doctors and hospital beds be needed in the area by the end of the next 10 to 20 years?

[1]Investigation of Manpower Resources. Hearings before Subcommittee of Senate Committee on Education and Labor, 77th Cong., 2d Sess., on S. Res. 291. Part 2. 1943. P. 662. Procurement and Assignment Service adopted this standard "as a basis of planning on a national scale" during the recent war. It was considered "the minimum below which it would be unsafe to reduce civilian medical service."

[2]U. S. Public Health Service, Division of Hospital Facilities. Study Guide for Hospital Planning. 32 pp. Washington, D. C. 1947. P. 18.

[3]Title 42 - Public Health. Chapter 1 - Public Health Service, Federal Security Agency. Subpart B - Distribution of General Hospital Beds. Reprint from Federal Reg. 21 pp. Washington, D. C. 1947. P. 2, par. 10.13.

B. *Measure resources for personal health service by adequacy to meet customary demand for service*

1. Statistics for the country as a whole show that for hospitals of less than 50 beds, about 6 out of every 10 beds will be used on an average day. For hospitals of 50 to 100 beds, about 7 out of every 10 beds will ordinarily be in use.[4] How does the number of beds in local hospitals occupied on an average day compare with these Nation-wide averages?

2. Have doctors, dentists, nurses, or other personnel left the area during the last 5 to 10 years because the demand for their services was insufficient to keep them in the area?

3. Have hospitals closed their doors because there has been too little demand for their services?

4. Do reports of customary family use of medical, dental, or hospital services indicate habits of health neglect? If so, what reasons are given?

5. Do reports of customary family use of service indicate failure to use services available within area? If so, what reasons are given?

C. *Measure public health services available to area by standards of adequacy*

According to the American Public Health Association, providing "basic and reasonably adequate local health services" would require the following full-time employees: a medical officer, sanitary engineer, sanitarian, 10 public health nurses, and 3 clerks.[5] Such a public health unit could serve a community of 50,000 persons. In sparsely settled areas, a community including that many persons might extend over several counties.

D. *Measure local financial resources for providing and maintaining health services*

1. What amounts are families *willing* to pay annually for health as indicated by their customary annual health expenditures?

2. What amounts are families *able* to pay as indicated by typical family cash income?

[4]Commission on Hospital Care. Bachmeyer, A. C., M.D., Director of Study. Hospital Care in the United States. 631 pp. The Commonwealth Fund. New York. 1947. P. 325.

[5]Emerson, Haven., M.D., Chairman, Subcommittee on Local Health Units, American Public Health Association. Local Health Units for the Nation. 333pp. The Commonwealth Fund. New York. 1945. P. 2.

Approximately $5 out of every $100, or 5 percent, of the cash income of farm families during 1941 was used to pay doctor, dentist, hospital, drug, and other bills for sickness or accident.[6] Of course, this is in part an indication of what families are *willing* to pay rather than an accurate measure of what they are *able* to pay. Nevertheless, the average amount farm families have spent for health in the past is a realistic measure of what they are likely to be able and willing to spend in the future.

3. How many families participate in insurance or prepaid service plans of various types?

   What type of plan has been most popular?

   What items of expense does this plan provide for?

4. Is a large part of the area's income derived from agriculture so that the total income is likely to be affected by hazards of weather, insect pests, changes in farm prices, and other uncertainties associated with farm income?

   What is the income range within which planning must be done as indicated by variations in the area's income over the last 10 to 20 years? (These variations, of course, also reflect changes in individual family income and ability to pay for health services.)

   Judging by the total income of the area and its variations from year to year, can adequate support for health services be provided now and assured for the future?

   Recognizing that not all areas need a hospital, since some have their requirements taken care of by hospitals in neighboring areas, current estimates of the cost of providing and maintaining hospital service may still be useful as a standard by which to measure the ability of the local area to support health services.

   The replies of architects and contractors all over the country to a questionnaire circulated by the American Hospital Association in 1946 indicate that the cost of building, equipping, and supplying a hospital amounted to about $8,800 per bed at that time.[7] Present prices, however, run about 20 percent higher than those in 1946. The cost of annual operation is estimated to be about one-third of the original cost of construction.[7] Of course, costs vary considerably in different areas because of local differences in costs of labor and materials.

[6]U. S. Bureau of Labor Statistics. Family Spending and Saving in Wartime. Bull. No. 822. 218 pp. Washington, D. C. 1945. Pp. 71 and 76. Money income of farm families of 2 or more persons during 1941 amounted to $1,163. Their outlay for all medical care expenses amounted to $62.

[7]McGibony, J. R., M.D. The 50-Bed Hospital - Its Planning and Costs. 4 pp. Reprinted from The Modern Hospital. December 1947.

See also McGibony, J. R., M.D. Community Clinic Designed for Rural Needs. 6 pp. Reprinted from The Modern Hospital. March 1946.

V. EXPLORE POSSIBILITIES FOR IMPROVEMENT

After the health council completes its appraisal of the area's situation, it can start exploring possibilities for improvement such as the following:

A. Possibilities for expanding and extending health services now available in the area.

1. Can outlying clinics be established in small trading centers, with each clinic open at stipulated hours every week and served by one or more doctors and nurses from a larger center?

2. Can arrangements be made for specialists from within the area or nearby to visit hospitals and clinics within the area periodically?

3. Is it possible and feasible to use mobile units to provide dental care or other services to all parts of the area?

4. Can ambulance service be provided or improved in order to make hospital care reasonably accessible to everyone in the area? Is the area so sparsely settled that air ambulance service seems desirable? Is it feasible?

5. Can the services of public and voluntary agencies be used to better advantage?

   Can well-baby clinics and school health clinics, for example, be set up to promote better health among infants and school children?

   Can X-ray and laboratory services provided by public or voluntary agencies be used more effectively?

B. Possibilities for attracting and keeping doctors, nurses, and other health workers

1. Are facilities available for up-to-date professional work including hospital or clinic facilities or at the minimum a well-equipped office?

2. What can be done to overcome the professional isolation that is the common lot of country doctors? Can intercommunity or inter-county medical and hospital councils be established leading to development of working relationships among the various individuals and institutions providing health services?

3. Can opportunities be offered for attending professional meetings? Can encouragement and possibly financial assistance be offered for attending periodic refresher courses? Can regular vacations be assured?

4. Can incomes be offered comparable to those offered elsewhere?

5. Is attractive housing available? Does the area offer good public schools and library facilities? Does if offer opportunities for recreation?

6. Can arrangements be made with medical schools or nurses' training institutions to provide experience in the area as part of regular training courses?

C. *Possibilities for providing and maintaining additional or improved health facilities*

1. If new or improved health facilities seem to be needed, what would be most suitable in view of the needs of the area as measured by (a) comparison of existing facilities and services with those considered essential for maintaining health; (b) customary family use of personal health services; (c) ability of individual families and area as a whole to support health services?

2. Where does the area fit in the State plan for construction of hospitals and other health facilities? Is it assigned priority in the State plan?

3. In case unapproved hospitals are operating in the area, what would be required to bring these hospitals up to the standards for approval?

   If local hospitals have been closed, could they be rehabilitated at a reasonable cost to meet approval standards?

4. How much probably can be raised for building new facilities or improving old ones through such methods as the following:
   Voluntary contributions and gifts?
   Special drives?
   Bond issues?
   Initial membership fees in a supporting organizations?
   Other methods?

5. In case local financial resources for construction seem likely to be inadequate, what outside resources might be drawn upon including State or Federal funds, grants from philanthropic organizations, and others?

6. What are the possibilities for raising funds to maintain local health facilities and services through:
   Fees for service paid by patients?
   Payments from insurance or prepaid service plans?
   Voluntary contributions and gifts?
   Tax funds?
   Annual membership dues or other contributions from a supporting organization?
   Other methods?

D. Possibilities for organizing payment for service

1. To what extent might organizing payment for service within the area make it possible (a) to provide assured support for needed local facilities and services and (b) to help families budget their health expenses?

2. What experience have people in the area had with prepaid service or insurance plans?

3. What type of organization for payment seems best from the point of view of:
   Providing support for services most needed?
   Typical family needs, use of personal health services, and expenditures for health?
   Total financial resources available?
   Experience of families and interest in organizations of different types?
   Other considerations? (See figure 10).

VI. BRING WHOLE AREA INTO DISCUSSION AND PLANNING

Once the health study and planning council has completed its investigations and appraisal of the area's health situation, it is not enough for its findings to be discussed within the council alone. Instead the whole area must be brought into the discussion and given an opportunity to contribute to planning based on the facts. Only in this way can a health program be worked out which will be widely understood and accepted.

A. Suggested methods for bringing whole area into the planning

1. Discussion at regular or special meetings of the organizations represented in the health study and planning council

2. Discussion at local community and area-wide meetings sponsored by the council

3. Articles in publications of organized groups in the area and in local newspapers

1. Does the plan help get and keep competent doctors and other health workers in the area -
(a) by assuring them regular, adequate income;
(b) by providing them workshop and tools to furnish efficient, up-to-date service?

2. Does the plan assure subscribers of well-rounded health service including general medical care, specialists' services, and hospital care?

3. Is the plan sound financially?

4. Are costs of administration a reasonable proportion of income? (Costs and income will have to be estimated if a new plan is developed locally.)

5. Does the plan clearly separate business administration of a prepayment system from practice of medicine?
Does it eliminate the possibility of interference in the customary professional relationship between doctor and patient?

6. Does the cost to subscribers fit the typical family's pocketbook?

7. Is enrollment open to substantially all families in the area, thereby promoting community health and community support of the plan?

8. Does the plan encourage membership interest and support by stimulating active membership participation?

9. Does the plan help reduce the frequency and seriousness of illness by encouraging people to go to a doctor before an ailment becomes extremely serious?

10. Does the plan provide education as to what good health means, how it can be maintained, and its advantages to the individual and the community?

Figure 10. - These 10 yardsticks suggest points to be considered in comparing a prepayment plan.

4. Informational programs on local radio stations

5. Neighborhood discussion groups

VII. SET UP GOALS AND PROJECTS

Out of the general discussion, thinking will gradually crystallize. The answer to the question, "What to do?" will gradually become clear. At the same time, area-wide discussion can be expected to develop interest in the support for any projects that may be adopted.

A. Standards for judging suggested projects

1. What can this project be expected to accomplish in building better individual and community health?

2. Is this project feasible in view of the general situation in the area and its financial resources?

B. Types of projects

1. Short-term

Among the short-term projects which might be adopted are the following:
Mass X-ray for tuberculosis
Fly control campaign
Improving garbage disposal methods
Investigating and improving drinking water supplies
Community clean-up campaigns

2. Long-term

Some projects for local health improvement cannot be carried out in a few weeks or months. Among such projects are the following:
Securing the services of a public health unit
Building a local community clinic
Financing of medical or nursing education or training as laboratory workers for local boys and girls
Developing and putting into operation a plan of organized payment to enable individual families to budget health costs and to provide support for needed health services

VIII. PLAN FOR CARRING OUT PROJECTS

A. Sources of information and assistance

The responsibility for carrying out health projects rests primarily on local people and their organized farm, business,

professional, church, and social groups. They will find information and assistance available to them from many sources, however. Among possible sources are:

1. County agent and home demonstration leader

2. Local public health officials, medical societies, hospital administrators, and officials of voluntary health agencies

3. State Health Department and State Extension Service

4. U. S. Public Health Service and Department of Agriculture

5. Cooperative Health Federation, Chicago. (This organization offers assistance to groups interested in forming a cooperative health association.

B. Short-term projects

To carry out specific short-term health projects, special temporary committees might be set up in the area.

C. Long-term planning and activity

An area-wide health study and planning council might be set up as a permanent organization to keep informed concerning local health conditions and to propose changes in local services that may be needed from time to time.

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*Publications marked by an asterisk are available from your State health department or other State agency in charge of administering the hospital law. Single copies can also be obtained, on request, from the Hospital Facilities Division, U. S. Public Health Service, Washington 25, D. C.